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## The Nurse in the School Health Office: Exploring Health Care in a Public School

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THE NURSE IN THE SCHOOL HEALTH OFFICE: EXPLORING HEALTH CARE IN  
A PUBLIC SCHOOL

by

Pamela A. Rademacher

A DISSERTATION

Presented to the Faculty of  
The Graduate College at the University of Nebraska  
In Partial Fulfillment of Requirements  
For the Degree of Doctor of Education

Major: Interdepartmental Area of Educational Studies

Under the Supervision of Professor Stephen A. Swidler

Lincoln, Nebraska

May, 2012

# THE NURSE IN THE SCHOOL HEALTH OFFICE: EXPLORING HEALTH CARE IN A PUBLIC SCHOOL

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University of Nebraska, 2012

Adviser: Stephen A. Swidler

To provide a high-quality education for all its students, schools must address a variety of needs that are related to physical, social and/or emotional health. School nurses are positioned to do that in the schools that they serve. Exploring how the school nurse intervenes to help children and their families to maintain a high level of health may contribute to an understanding of health care and academic achievement in the educational community. The purpose of this qualitative study is to gain an understanding of what a nurse does on a regular basis to provide health care to all children in a public school at the preventive and primary care levels in the United States health care delivery system. In an effort to contribute to existing knowledge about the relationship between health and education outcome, this year-long study utilized an ethnographic approach to examine what a particular school nurse does within the context of an elementary school with an enrollment of over 500 students and a 92% poverty rate. The findings strongly support that the school nurse interacts with children and staff in caring ways to: 1) negotiate daily medication administration to manage chronic illnesses according to district policy and nursing practice; 2) manage the treatment of episodic health complaints; and 3) record and communicate health information. Together they provide an understanding of the school nurse 'caring for' and 'caring about' children's health to improve the possibility that they will be in their classroom.

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## CHAPTER ONE

### Introduction

Bre, a fifth grade student, enters the Health Office complaining that she has a headache. Ann notices her, "I think it is time to get rid of it. Let's check your temperature, 98.6." Then questions begin, "When did your head start hurting? Did you tell anybody else? Did you bump your head?" Ann looks at the child's eyes and listens carefully to her answers to each of the questions. "Your eyes were telling you to sleep and your head was telling you not to sleep." As the two talk, Ann is at her computer entering data. Looking directly into Bre's eyes she adds, "You have been complaining of headaches for over a week now. I can give you some Tylenol. Let's weigh you first. Do you want liquid or chewable?" Bre picks adult pills because that was what she said her grandmother gave her. Ann comments, "I need to do that too; you kids are getting so big." Opening a bottle of pills she continues, what would you do if you were an adult with a headache?" Bre says that she would stay home. Ann fills a paper cup with water, and says, "If you stay home, you don't get paid; I like your glasses. Have you always had them? You will want to tell your mom that your headaches may be from your new glasses. Tell her that you might need to check with the eye doctor to make sure you have the right ones." 4/18/11

This was not the first time I had observed school nurse Ann engaged in mundane caring for a student with a headache, but it was amongst the most revealing. As this face-

to-face encounter with the child unfolded, it hinted at the multiple roles a school nurse is expected to assume in her day-to-day activities, such as caring for children's physical complaints, administering medication, and tracking information. It brought to the fore a nurse listening and being receptive to a child's need for attention to her physical complaint. Then while providing medical care for the physical problem the two communicate, engendering discourse that connected them informally as teaching and learning took place. As a medical caregiver, Ann provides care that included administering a pain reliever. In this instance, Ann introduces the student to the larger conversation of adult health management addressing how to manage health and to make healthy choices when she becomes an adult.

This scene from my fieldnotes serves to introduce the study's primary participant, Ann, the school nurse at Wiggle Creek Elementary, and introduces the pattern of caring behavior that frequently occurred throughout the year-long study of this school nurse.

Along with introducing medical care giving and teaching, my fieldnote also reveals nursing practice. Ann initiates a response to Bre gathering subjective information using a question and answer format: When did your head start hurting? Did you hit your head? Ann then gathers objective information. In this instance, it was checking the child's temperature. Since Bre's parents had authorized (signed a consent to administer) Tylenol, Ann had treated the complaint, an act that was contingent on the subjective and objective information that she had gathered, and in accordance with district policy for dispensing medication and nursing practice. Other times, I noticed that Ann requested that a child with a headache lie on one of the cots (five minutes or so for continued

observation and assessment of physical symptoms), gave them an ice pack to put on their forehead, or in some cases suggested that they have a drink of water.

The overarching significance of this encounter is that Ann had entered into a caring relationship with Bre. She had responded to Bre's physical need and she was responsive to her other needs as they interacted informally. Bre's response to engage in a conversation characterizes her contribution to the caring encounter. Encounters such as this occurred repeatedly throughout the year I observed at Wiggle Creek Elementary. While most children left the office to go back to their classroom, there were exceptions to that. For example, a child would be sent home when Ann's nursing assessment identified a fever, rash, or other conditions that could affect the well-being of the child and the safety of others (Health Services, 2010).

Exploring the efforts of a particular school nurse as a year-long qualitative study is a useful endeavor. It provides an in-depth detailed description of the school nurse as a medical caregiver and as a teacher showcasing a school nurse's caring actions as they are enacted in regular and redundant ways. This study provides insight about health care and the nuanced ways it occurs. And, it may ultimately help to better utilize the school nurse to improve meeting the health needs of all children, especially underserved populations such as the students that Ann served at Wiggle Creek Elementary.

While at the school, I always situated myself in a child-sized chair along the south wall of the health office (See Appendix A for sketch of the room.). It was from this position I observed Ann's interaction with the children and other adults, especially her interaction with Beth the full-time health technician. The child-sized chair presented me as low to the floor, a visitor of sorts. While the children talked to Ann, I busied myself

with looking around the room taking in the ambience. I hoped that the children that came for episodic care and their daily medications would observe me not doing anything in particular, and as just someone there.

I also accompanied Ann to staff meetings and to classrooms when she taught health curriculum. At meetings, she introduced me, and then I would brief those present about my study of what a school nurse does. In my briefing, I always assured those present that my study was not about the children. When Ann taught in the classroom, I simply arrived with her, immediately located a chair in the back of the room, and situated myself there. Other adults were situated in the back of the room too. My perception was that my presence was limited to that of one of the other adults in the back of the room not engaged with the children or their teachers.

### **Research Problem**

The role of the school nurse is more than applying Band-Aids, giving out ice packs and checking temperatures. It has evolved into a multifaceted role, one that provides health care services for all children not only while they are at school, but also in some instances, while they are homebound (Passarelli, 1994; NHHS, 2011).

For more for more than a 100 years, the school nurse has provided health care to U.S. public school students. In the early years the school nurse focused on stopping the spread of contagious diseases; today school nurses continue to do that, but they find there role has a more balanced approach. Not only, do they monitor the spread of disease, but they also work towards preventing health problems and helping students manage their chronic health problems.

### **Taken for Granted Role**

The role of the school nurse is often taken for granted because schools are focused on educating all children to meet specific educational standards. This focus shifts the emphasis to educators and their accountability to ensure that all children meet educational standards. It overshadows the health status of children and the effect health has on academic outcome. Nevertheless, the school nurse represents health care in the educational milieu, but often must function outside education towards achieving a high level of well being for all the children enrolled in the school.

The fact that a health care provider works in an educational setting gives rise to an interesting convergence of practice. The school nurse occupies an in-between space, of sorts, that is regularly concerned with educating and health caring. In other words, sometimes the school nurse is a health care professional and sometimes she is an educator, but most of the time she is both, in the ongoing process of helping children maintain a status of a health that is essential for learning. Examining this intersection helps to get to the heart of health care in a public school. It uncovers what the nurse regularly does - daily and/or cyclic - providing access to health care in a particular setting for all children. Understanding what a nurse does in a school has the potential of impacting academic achievement for all children while they are enrolled at school. When a school nurse serves the children, they all benefit from having a health care provider ready, at no cost, available to meet their health needs. Further, meeting children's health needs while they are at school impacts that children will be in their seats. However, one must be cautious interpreting the relationship between increased time in the classroom, the efforts of the nurse to keep children there, and the outcome of academic achievement (Geierstanger, Amaral, Mansour, & Walters, 2004). Caution is necessary because of the multifaceted



nature of academic achievement. It is more likely a whole school effort, and the nurse is a part of that effort. Exploring what a school nurse does to keep children in their seats focuses attention on the relationship between health care and education outcome.

In probing the gamut of ways the health office represents both health care and education, and their convergence in US public schools, this study engenders a renewed understanding of the significance of the complex relationship that exists between student health and educational outcome (Maughan, 2003; Geierstanger, Amaral, Mansour, & Walters, 2004). In a published comprehensive literature review, Symons, Cinelli, James, & Goff (1997) bring together the work of many researchers to “confirm a strong relationship between health risks and education outcomes” (p. 8). Faupel, Horowitz, & Weaver (2004) confirm the relationship and add that serious health hazards associated with “recreational drug use...[are often the] consequence of lifestyle milieu in which these drugs are taken” (p. 252). The school nurse, as a health care professional, functioning within local and state rules and regulations, is positioned to serve students in an elementary school; she is prepared to intervene when they arrive in her office ‘unhealthy’ in providing health care that enables them to get back to their classrooms rather than be set home. Keeping children in school is an important role of the school nurse (Maughan, 2003). What Ann does to keep Wiggle Creek children well and in their classroom is an important story to tell. It informs about what one nurse does to address the health needs of the children.

### **Health Care in the School**

Those involved with children on a daily basis, such as teachers, school nurses and other staff members, notice poor health lifestyles and are familiar with symptoms and

behaviors that result because of it. But, the children, because of poor health lifestyles, often do not know or associate lifestyle and wellness status, and subsequently do not take steps to improve their health status (Symons, Cinelli, James, & Goff, 1997).

**Health status and academic achievement.** Particularly salient are behaviors that occur in the classroom that are directly related to negative educational outcome, such as tiredness, chronic absenteeism (e.g., poor management of chronic health problems, frequent infections, poor nutrition), and antisocial behavior that often turn violent (Wyman, 2005). And, because of the day-to-day nature of the school nurse's work, it is reasonable that she is in the position to have specific health knowledge of individual students. For example, they may be arriving frequently for the nurse's care on a daily basis for health conditions such as sleepiness, or recurring upper respiratory system illnesses. This knowledge serves to help her intervene (i.e., direct health care and health education) to prevent health problems that might interfere with learning and poor educational outcome (e.g., asthma management when parents smoke).

Sometimes, struggling students themselves might notice problems that a visit to the school nurse could alleviate. For example, the school nurse might intervene on the behalf of a child struggling with the management of a chronic condition such as Attention Deficit Disorder and the negative side effects that the management medications can produce. In this instance a school nurse, being familiar with individual health needs (including medications and their proper administration), can quickly recognize the cause and effect of meal skipping and the subsequent undesirable side effects. For example, she might send the child to the cafeteria for food, and follow up with allowing them time

to eat in her presence. An intervention such as this enhances the child's ability to learn in the classroom and promotes self-management of their chronic health condition.

**School nurse role as educator.** Besides caring for individual health needs, the school nurse also provides education about disease prevention, manages student health records, and is called upon to provide instruction for a variety of issues related to healthy lifestyle choices that support wellness (Healthy Schools Campaign, 2010). In addition, the school nurse is expected to communicate with parents and teachers on a variety of matters, encourage good hygiene (e.g., hand washing direction/instruction in her office), monitor emerging communicable diseases (e.g., H1N1) and report the absentee numbers to the state health department (NASN, 2003).

The school nurse's district, her professional nursing practice, and her professional license provide the framework for what she does (See Appendix B). While this might frame what is generally expected, she may take on additional roles to meet changing health related needs of the local population (Healthy Schools Campaign, 2010). The convergence of the nurse's activities, albeit varied, functions to maximize the time students spend in their classrooms.

**Access to health care in school.** Foundational to engagement with school is the elimination of barriers to education and health care. Language can be one of the barriers. Shin & Bruno (2003) report 8% of individuals five and older had difficulty with English. Statistically, that translates into communication barriers with parents and their children that a school nurse might encounter as she provides health care in direct and indirect ways. For example, it is reasonable to assume that in health information gathering (e.g., student compliance with state required immunizations) language barriers must be

addressed to provide health care at school that is free and ready for the students. Some districts likely confront language barriers more than others depending on the demographics of the school population. The use of translators reduces the language barrier to communication that is necessary with parents about health screening deficiencies and immunization noncompliance.

### **School Nurses Provide Health Care to a Significant Portion of the U.S. Population**

It is estimated that 34.9 million children and youth attend public schools each day in the U.S. (National Council for Education Statistics, 2010). While student visits are largely episodic and cyclic in nature, the nurse has access to the child on a daily basis. Likewise, the child has access to the nurse; it is free and ready on a daily basis. Chamberlain and Bauer (2004) suggest that ideally the nurse-to-student ratio should be approximately 1:750, however, that is not always the case. In reality, that ratio is adjusted to meet population demands and funding. Further, recent public school attention has focused more on education outcomes than the health status of its students. The result of such a focus has reduced funding in some instances for health care at school. For example, Cramer and Iverson (1999) suggest that some school districts were forced to respond to cost saving measures, and reduced their school health programs to a minimum to meet required mandates reflective of the state screening and immunization compliance. In addition, Cramer & Iverson found that evaluation of school health programs were limited to “structure and and/or process data such as, number of activities performed, number of services provided, number of visits to the nurses office and cost of resources” (Cramer & Iverson, p. 52). Evaluating school health care in schools by the numbers

underestimates the value of the school nurse's effort that can reduce health problems and costs.

### **School Nurse and Cost of Health Care**

In recent years, society has focused on cutting health care costs. As current legislation is implemented to do that, attention is likely to shift to schools promoting access to health care for all children. Especially when *all* is defined, as not only the children with a high level of health status, but also those children with “developmental delays and disabilities, children whose families are culturally and linguistically diverse, and children from diverse socioeconomic groups (Berns, 2009).

### **Federal Legislation**

Also, in describing the milieu of school nursing, one must consider federal laws that are tightly woven into the fabric of public education and the health care that gets provided at school. These laws drive the activities that the school participates in, and allows for more children than in the past to function in an educational environment because of the care that the nurse can provide to support their physical needs in the classroom. For example, when the government required that schools provide appropriate education of disabled students that had not attended school in the past through the Individuals with Disabilities Education Act (IDEA) Public Law 105-17, it changed the demographics of the school population. As a result of this legislation, the school nurse was required to provide for these children in ways such as tube feedings and breathing assistive devices on a daily basis. Other legislation, such as No Child Left Behind (NCLB) also drives what a school nurse is expected to do so all children can learn and

make yearly academic adequate progress. NCLB also holds the school accountable for the effectiveness of the care that the school nurse provides.

The research literature suggests that we can learn informally about the role of the school nurse. For example, Hull's (2008) article "School nursing: Are you up to the challenge?" typifies what we know from a first person account of a nurse's daily activities. What has not been sufficiently documented is what the school nurse does from her perspective as observed by someone else to understand how students' health needs are provided for within a diverse population such as the one found at Wiggle Creek Elementary.

Accounting of what one school nurse does could easily be lost in a study that relies on objective methods – questionnaires, frequency counts and the like. As Wolcott (2003) so aptly puts it, "human beings get lost in masses of figures" (p. xviii). This study fills that gap in our understanding of school health care.

### **Research Purpose**

My rationale for pursuing a qualitative study stems from the fact that almost no attention is given to what a nurse actually does in a public school to provide health care. Especially limited is an in-depth study of it from the school nurse's perspective. Ann described it this way: "What we do... is make sure kids are healthy... [so they can] academically perform." This is accomplished through describing the school nurse's regularly enacted duties to care for children while they attend school.

The purpose of this study is to describe health care in an elementary school from the perspective of the school nurse. This study a) explores what a school nurse does on a regular basis to provide health care that equips students to improve their well being to

regularly be present in their classrooms, and b) describes the indirect health care that also increases student's ability to regularly be present in their classrooms.

The study frequently refers to the notion that the school nurse is positioned to help in the process of educating children, and describes how she frequently does that. In addition, it describes how the nurse serves as an advocate for all students in the particular building that she is assigned in ways that are expected and in ways that are unexpected. Attention to one school nurse (Ann) as she described her activities (i.e., how she provides for the health care needs of a diverse student population and how she equips the children to be able to go back to the classroom better prepared to learn) "mak[es] sure that the obvious is obvious" (Wolcott, 2003, p. xvii).

### **Research Questions**

The central research question that guided this inquiry is: What does a school nurse do in an elementary school? Subsequent questions that are also addressed during the study at Wiggle Creek Elementary include: Who is the school nurse? How does she define her role? What accounts for her acting in the ways that she does? The particulars represent primarily the perspectives of the school nurse as she described for me the role of the school nurse. The school principal, and the health technician were also invited to describe from their perspective what this school nurse does. They also provided answers to the research questions.

### **Organization of the Report**

To gather data for this year-long study, I regularly observed Ann engaged in the practice of nursing while at Wiggle Creek Elementary School. In addition, I conducted formal and informal interviews and gathered school and district artifacts (paper and

electronic) that pertained to school health. Together these sources of data provide an in-depth description of what the nurse does when she encounters the realities of health care in a public school setting. In other words, this study brings into (re)view intricate patterns of relationships that converge in describing what a school nurse does in a particular context and time. Chapter two reflects on why study the role of the school nurse. This chapter reviews the literature to frame the study from the larger conversation of what school nurses do to provide health care in an academic setting. Chapter three discusses the steps taken to answer the research questions. In this chapter I discuss how I inserted myself and describe my position as a researcher. The chapter also provides a discussion of the role of theory, and descriptions of accessing the study site, selection of participants and their recruitment, study design tools, and ethical considerations. Chapter four introduces the study's primary participant, Ann, the Wiggle Creek school nurse and discusses her perspective/stance that defines who she is. It also introduces the study site.

Chapters five through seven present the study data/findings enacted as medical caregiver and teacher. These chapters showcase her role as it is enacted at Wiggle Creek – common, regular and redundant observed behaviors and her stories of these obtained through the informal conversations that Ann and I regularly engaged.

Chapter five identifies and describes regular and redundant ways that the school nurse responds to the behaviors associated with students receiving their daily medications. Chapter six enlightens about the regular and redundant ways she responds to the children's physical needs. Chapter seven explains and highlights her role as a keeper of health records. When viewed as the daily activities that a school nurse regularly participates, they present a compelling story of health care in an elementary school.



Chapter eight discusses and summarizes the study findings and situates the study within the larger conversation of health care and education.

## **Chapter Two**

### **Literature Review**

The literature is reviewed in three key areas to provide background and context for this study. First, I explore the practice of nursing. Second, I consider the changing role of school nursing as it relates to the changes in student populations and medical technology. The final section of the literature review focuses on the current status of school nursing. This approach presents a broad spectrum from a historical, social, physical, practical and political perspective to inform about the central research question: What does a school nurse do in an elementary school?

### **Nursing Background**

Potter & Perry (2009) establish that nursing is both an art and a science. It is an art in that care is “delivered artfully with compassion, caring, and with respect... for the dignity and personhood” (Potter & Perry, p. 2) of the ones ‘cared for’. It is a science in that those trained to become nurses have studied a scientific body of knowledge and learned the skills required of the training. When the art of nursing and the science of nursing are integrated as practice the result is the provision of the kind of quality care that benefits the client (Potter & Perry). When nursing is practiced in schools it is defined as a “specialized practice of professional nursing that advances the well-being, academic success and lifelong achievement and health of a student... to facilitate normal development and positive student response to interventions” (NASN, 2010, p. 1).

### **Nursing Practice**

Nursing in general and school nursing practice both rely on the concept of ‘caring for’ individuals that have a health related need; it is primary to nursing practice. Boykin

& Schoenhofer's (2001) nursing as caring theory is useful to conceptualize caring as it relates to nursing practice. The "caring perspective...is basic to a view of nursing as an undertaking that focuses on humans, provides service from person to person, exists because of a social need, and is a human science" (p. 542). Further, Potter & Perry (2005) suggest that "when clients sense a commitment on the part of the nurse and are willing to enter into a relationship" (p. 110) with that nurse it allows the nurse to gain an understanding of the client's experience of illness. To that end, specific activities that the nurse engages in are such things as "presence, eye contact, body language, voice tone, listening, and having a positive and encouraging attitude." (p. 113) Also, the nurse engages in touch, knowing the client, spiritual care and family care. These possible interactions create the caring acts that characterize nurses, which also is a motivating force for people to choose to become a nurse (Potter & Perry).

Pulcini, Couillard, Harrigan and Mole (2002) suggest that the ability to provide excellent health care is associated with personal characteristics that are associated with the concept of care. Their study contributes personal and professional characteristics of professional nurses. Using the Delphi technique to obtain national expert consensus of characteristics, they concluded that the top five personal characteristics of nurses were communication ability, honesty, trustworthiness, a caring attitude, and ability to prioritize; a list that parallels the characteristics of a caring person that Boykin & Schoenhofer suggest in nursing as caring theory.

Looking to Swanson's caring theory also helps to conceptualize the nursing concept of caring. She defines it "as a nurturing way of relating to a valued other, toward whom one feels a personal sense of commitment and responsibility" (p. 109, Potter &

Perry). Interestingly, little is known about teaching caring practices (Hoover, 2002).

Hoover's cohort study enlightens about how education might enhance the capacity to care, at least from a personal perspective. She found that teaching caring might better prepare nursing students for the capacity to care for their clients.

### **Nursing Autonomy**

In the past the school nurse functioned alone; she was the sole health care provider within the educational community. Felton & Keil (1998) and Smith (2004) acknowledge in their research the need to provide the means for a newly hired school nurse to move their practice toward autonomy suggesting the need for specialty education and peer mentoring as participants develop in their autonomous role as school nurses and to advance school nursing practice situated in an educational context. Smith's (2004) study examined marginalization of the school nurse, and also suggests that to decrease isolation, role confusion, and barriers to practice, school nurses might benefit from increasing their visibility and collaborative opportunities in the educational and nursing communities.

Today the school nurse functions within an educational system to provide for the needs of children's academic and health status. This coordinated system enhances the probability of providing for health and educational needs not only at school, but also at home, and in cooperation with other health care providers and community resources (Wolfe & Selekman, 2002).

### **School Nurse Evolving Role**

The role of the school nurse developed gradually and changed over the years to meet the needs of the changing student population. Health concerns of students addressed by the school nurse in the past persist today, however other influences determine what a school nurse is expected to do.

#### **Early Years**

The idea of a state licensed registered nurse employed by a public school district to provide health care to its students is not new. For more than a 100 years the school nurse has played a central role in the nation's health care system in the public school setting (Fleming, 2009; Wolfe & Selekman, 2002). It is generally agreed upon in the discourse found in nursing practice literature that in 1902, school nursing emerged from the Henry Street Settlement's public health model (Wolfe & Selekman, 2002). The Henry Street Settlement also provided the salary for the first New York City public school nurse, Lina Rogers Struthers, R.N. (Henry Street Settlement, 2011). Struther's efforts to control communicable diseases and to keep children in school was so successful that it led to the hiring of more school nurses not only in New York City, but also throughout the United States.

#### **The School Nurse and Absenteeism**

Prior to the school nurses effort to control disease, medical doctors had been hired to inspect children, and when a child was diagnosed with a communicable disease the doctor sent them home - an act that directly affected absenteeism. School nurses tried a different tactic. To decrease absenteeism school nursing activities expanded to include such things as promoting hygiene and teaching students healthy living skills (Henry

Street Settlement, 2011). These activities (the treatment of acute illnesses and injuries) dominated school nursing practice throughout the first half of the twentieth century (Wolfe & Selekman, 2002). It is not surprising that the nurse's role expanded to meet the health needs of children attending school at the time; a continuous attempt to accomplish Struther's original goal of increasing the health and well being of children to produce better learners.

The logic follows that children that are in their classroom will have a better outcome than those children that are not in the classroom. Interestingly, Struthers in her 1917 book suggests that the efforts of the "nurse's work in school increased attendance fifty percent. Interested and regular attendance took the place of exclusion and truancy." (p. 8). Since Struther's work, others have followed in her footsteps to research the relationship between school nurse activities and absenteeism. One example is Weismuller, Grasska, Alexander, White, & Kramer's, 2007 study examining the relationship of absenteeism of elementary school students and nurse interventions. Their retrospective review of 240 randomly selected student health folders and attendance records found that while there were anecdotal reports of effective school nurse (SN) interventions there was little evidence documenting referral to the SN for attendance problems. Since their focus was on outcomes, which were poorly documented in the records, accounting for the relationship between student attendance rate and health outcomes was difficult to substantiate. Wyman (2005) and Van Cura (2010) also contribute to what is known about this relationship. Both authors suggest that contact with a licensed health care provider reduces absenteeism. School nurses are able to provide anecdotal reports of effective SN interventions in cases of poor attendance and

parental lack of knowledge that health conditions are manageable at school, but because the researchers found less than adequate documentation for why a child was absent, evidence to support that the nurse reduced absenteeism could not be supported (Geierstanger, Amaral, Mansour, & Walters, 2004; Weismuller, et al.). Further, Geierstanger, et al. acknowledge the complexity of interpreting attendance rates because of other factors besides interaction with the school nurse. Multiple factors likely influence attendance; suggesting a cause and effect between school nursing interventions and absenteeism has not been shown. While there is weak evidence to support that attendance is directly related to academic outcome; it clearly does not show any clear cause and effect relationship either. But rather is better understood as a relationship where increased attendance promotes the possibility of learning.

Coincidentally, Pennington & Delaney's (2008) study to determine if there was a difference in the number of students sent home when ill or injured based on who made the assessment to send the child home, found that 5% of students seen by the school nurse were sent home and 18% of students seen by an unlicensed school employee were sent home. These findings suggest that school nurses do intervene to help students manage their health and help them to stay in school while they do it.

School nursing activities related to immunization compliance diminish the possibility of school age children being ill. States regulate the immunizations that a child is required to have to attend a public school. The nurse is required to ensure that all children have complied with state law. The school nurse's participation in specific tasks such as mass school immunization is an example of how this is accomplished. Wiggs-Stayner, Purdy, Go, McLaughlin, Tryzynka, Sines, & Hlaing (2006) study of mass

influenza immunization found a reduction in absenteeism in the school that offered the mass immunization. Influenza, a seasonal communicable disease, where a high percentage of the population is vaccinated, can directly reduce student absences and thus increases the time children will spend in their classroom for instruction. School nurses are positioned to provide the vaccine while the students are in attendance at school for many of the vaccines, if the need arises.

### **Nurse-to-student Ratio**

With more than 34.9 million children in prekindergarten through 8th grade attending public schools each day in the U.S (NCES, 2010), student encounters with the school nurse no doubt get repeated in elementary school health offices on a regular basis. Statistics inform that in the U.S. 41.3% of schools have a registered nurse serving as the school's nurse (Burkhardt Research Services, 2007). Additionally, the statistics indicate that the nurse likely serves in two schools with a combined population of 1,151 students (Burkhardt Research Services).

To adequately attend to the students' health care needs, Chamberlain and Bauer (2004) suggest a nurse-to-student ratio of 1:750 for most school populations. Interestingly, Maughan & Adams (2011) found that a nurse to student ratio had little influence on educators and parents perceptions of the role of the school nurse, but rather their perceptions were more closely related to the interpersonal relationships that the nurse had with members of the school team and the parents. Maughan & Adams found that educators saw the nurse's role as one to reduce absenteeism. They found that "School nurses who were professional in their interactions, proactive and found ways to be valuable members of the [educational] team were well respected and valued by



educators” (p. 359).

### **Health of Children**

Researchers studying the health of U.S. children state that the increased rates of chronic illness (asthma, diabetes, and allergies) together with advances in medical technology, federal legislation and inclusion measures likely influence what a school nurse is expected to do too. It is estimated that 18% (Pastor, 2009) of children attending a public school will be affected by a functional disability. Children with chronic illnesses such as asthma and diabetes are affected at rates of 10% (Bloom, 2008) and 0.26% (2011 Diabetes Public health Resource) respectively. And emotional or behavioral conditions such as ADHD affect children at an estimated rate of 8% (Bloom, 2008).

### **Immigration**

Immigration trends in some school districts have created issues with providing health care in the affected district. Burkhardt Research Services (2007) in their survey study for the National Association of School Nurses found that in “communities with large immigrant populations, some school nurses mentioned spending large amounts of time overcoming language barriers and educating parents on how to access community health care services” (p. 8) especially in districts where multiple languages are represented and a high percent of the students participate in English as a Second Language (ESL) services. In such cases the school nurse will frequently communicate with families with limited English language skills (Whitman, Davis and Terry, 2010). In populations where limited language skills engender obstacles for health care, the school nurse may be the only source of health care for such students (Whitman, Davis, & Terry). Whitman, Davis, and Terry conclude that the school nurse can provide a “unique

opportunity to engage parents of ESL students in... the health care of their child” (p. 212). The school nurse can do this through her daily access in providing care interventions as she encounters children with limited English language skills in the school setting (e.g., health screenings, monitoring immunizations, and the like).

Caring for ESL students and their parents is likely contingent on the collaboration and cooperation within the educational system at both the school level and district levels to provide “school nurses with cultural facts and interpreter services... [to] reduce the barriers to access, eliminate disparities, and improve health and academic outcomes for ESL students” (Whitman, Davis & Terry, 2010, p. 212).

### **Government Influence on Changing School Nurse Role**

Along with the current status of children’s health and immigration, another factor that has changed what a school nurse does is federal legislation. Some legislation has resulted in an increase in the numbers of children enrolled in school that require management of chronic health conditions during the school day (AAP Council on School Health, 2008). Changing needs of children functions to drive the activities that the nurse must be skilled in and required to participate in, allowing for more children than in the past to function in an educational environment. One such law is the Individuals with Disabilities Education Act (IDEA) Public Law 105-17. It requires that public schools provide “free and appropriate education in the least restrictive environment” for disabled students between the ages of three and twenty-one years of age (National Dissemination Center for Children with Disabilities, 2010; Wolfe & Selekman, 2002). No Child Left Behind (NCLB) is another federal law that influences what the school nurse (SN) does, and it holds the school accountable for the effectiveness of the care that the SN provides.

Because of federal legislation requiring districts to provide for a variety of chronic health issues, school nurses now find themselves attending to such things as tube feedings and providing care for children with breathing assistive devices. Legislation and the advances in the field of medicine converge to pressure evolution of the school nurse's role into one that is no longer seen as one who simply applies band-aids or is the one responsible for determining if a student has a fever. It has evolved into a role that plays a significant role of caring for all children while they are at school.

### **Episodic Care to Chronic Care**

Advances in health care (e.g., medical technology) pressures practicing nurses to acquire professional nursing skills to adequately provide for a wide range of pediatric health needs. Improvements in nursing practice improve management of chronic illness (e.g., mobility issues of students, and meeting student needs with multiple handicaps) and as a result change student population demographics too. Yet for school nurses the goal remains the same – individual student success. To meet that goal school nurses respond to these changing needs of students through specific activities. For example, when students need skilled nursing care while at school, administrators and educators look to the school nurse to develop the Individualized Health Plans (IHP) for children with chronic health problems to participate in learning activities in the classroom. Also, the school nurse participates in separate Individual Education Plans (IEP) to accommodate health conditions in meeting educational needs (Wolfe & Selekman, 2002). As a member of the IEP team the nurse provides an assessment of the child's mental, social and physical needs to function within the educational setting, and can include recommending such things as self-care skills, monitoring chronic illness and limit spread of disease (a

special risk of medically fragile children) and behavior skills to promote learning (Wolfe & Selekman).

### **Current Status**

The American Academy of Pediatrics iterated that their position was that the school nurses provide direct care to students, including care for injuries and acute illness and the long-term management required of students with special health care needs. Pediatricians recommend that nursing activities associated with direct care, at a minimum, include assessment of health complaints; medication administration; care for students with special health care needs; a system for managing emergencies; completion of mandated health screening programs; verification of immunizations; infectious disease reporting; and identification and management of chronic health care needs of enrolled students (AAP Council on School Health, 2008). In addition, it is suggested that the nurse be expected to provide health education instruction for such things as disease prevention, nutrition, and safety. And, the school nurse is expected to manage all generated data related to these activities through regular documentation in the student's health records (Healthy Schools Campaign, 2010). In addition to the above activities, the nurse is also expected to communicate with parents and teachers on a variety of matters, monitor and report the absentee numbers to the state health department in an effort to control the spread of emerging contagious diseases (NASN, 2003).

What the nurse can do and actually will do is also prescribed by professional nursing practice, her professional license, and by the district that employs the nurse. Examining the study site's district's website and the National Association of School

Nurses (NASN) website enlightens about what is expected of a school nurse. These expectations appear as a list in Appendix B.

Changing health related needs of the local population may also drive what a school nurse does (Healthy Schools Campaign, 2010). This may be so because the school nurse is also a link to the public health department and to local emergency services. In their position statement for the National Association of School Nurses, Cagginello, Clark, Compton, Davis, Healy, Hoffmann, & Tuck (2011) state that the nurse serves as the conduit for “dissemination of public health information to the school community in the event of any ‘mass casualty event’ and provide[s] care for students.” The convergence of all the nurse’s activities, albeit varied, functions to maximize the time students will spend in their classrooms and enables them to learn to manage their health while at school.

My rationale for using an ethnographic approach to study what a school nurse does in an elementary school stems from the fact that attention to what a nurse actually does in a public school is limited in the literature, especially limited as any in-depth disciplined study of it from the nurse’s perspective. Hull’s (2008) anecdotal comments in “School nursing: Are you up to the challenge?” informally accounts for what we know of a nurse’s regularly repeated daily activities. Kreman (1997) examined the role of the school nurse in a rural setting. She found that the health needs of the student population were the driving force behind what activities the nurse regularly participated in to provide children with a safe environment to promote achievement of educational goals.

Disciplined studies have been completed for example to investigate the school nurse managing a specific element of her practice such as McCorkle’s (2005)

investigation of asthma management and student learning and Resha's (2006)

investigation of perceptions of leadership within the role of the school nurse. Others have suggested health care in the school (Clendon & White, 2000; Nelson, 2009; Guttu, Engelke, & Swanson, 2004; Fetro, Givens & Carroll, 2009, Resha, 2006), but what has not been sufficiently documented is the nurse's perspective to describe what she does.

This study examined the perspective of a school nurse as she provided health care to meet students' health needs within a diverse population of an elementary school located in a large school district. "This is accomplished by paying attention to the particulars, getting to the 'heart of the matter,' if possible" (Sarroub, 2005, p.3).

## **Chapter Three**

### **Research Methods**

The purpose of this study is to create an account (from the nurse's perspective) of what a school nurse does to provide health care in an elementary school. To achieve this purpose, the research design relied on broad general research questions that could be answered either through observational data or text that came from the participant(s). Throughout the year-long study I utilized a research cycle that included data gathering, followed by analysis, then more data gathering, and more analysis to uncover patterns of behavior that emerged as repetitive and regular acts.

In addition, the cyclic process allowed for addressing subjectivity (Corbin & Strauss, 2008; Creswell, 2008). This was addressed through listening to the views of the school nurse respond to general open-ended questions (formal taped interviews and our natural talk), reflecting on the text as generated, and asking myself what was going on in terms of how I see it and how the nurse sees herself. Embracing subjectivity as a concept that is interwoven into meanings compels me to look for complexity and to rely on my participants' views of the situation. To do that, I rely on thick description to allow for the voices, feelings, and actions of the study's participant to be heard (Creswell, 2007).

Wolf (1992) summarizes nicely when she described subjectivity as a process inviting the researcher "to listen to as many voices as she can and then choose among them when she passes their opinions on to members of another culture" (p. 11). To that end, Wolfe suggests "what gets chosen as data is not arbitrary, [but] neither is the testimony" (p. 11). Relatedly, how Ann answered the questions and the content of our informal conversations was also not arbitrary; it reflected our perspectives.

In this chapter I iterate important points related to my stance and the role of theory. I then describe access to the study site, selection of participants, and the study design. The chapter concludes with a discussion of study limitations, ethical considerations, and definitions of terms.

### **Researcher Philosophy**

My professional history is largely responsible for the vantage point that I bring to this study. It began in health care as a medical technologist in a large university medical center in the 1970s. The setting provided me with experience in a fast-paced, procedure-driven flurry of activity as a team member to provide health care in an acute care facility. Later, as a health educator in a middle school setting, my perspective re-enforced my use of a medical lens to focus on what I did there as an educator. Together these experiences broadened my understanding of how others and I construct knowledge. I view learning as an active, social process. And, from a researcher perspective, this stance embraces a co-construction of knowledge (i.e. in this study the school nurse and myself). My perspective allows for variability in how I conceptualize reality and knowledge. It does not create tension or conflict, but rather it gives me more possibilities for understanding the perspectives of others.

### **Ontological Assumptions**

My sense of reality is that it exists but it is not humanly possible to completely know it. I accept the possibility that reality exists as individual constructions of it. A memo that I wrote early on in the study, helps to enlighten about my stance related to the nature of reality. In this instance, I observed the health technician interacting with an Arab student that she suspected had faked physical symptoms (a hacking cough) to get



her to send him home. She told him to stop coughing; he did. Yet he continued to argue that he was sick. Later, I recorded questions speculating about the nature of reality in this instance: What is the source of his resistance? Is it fear, anxiety, or discomfort in the classroom? Does he perceive a threat to his sense of self, community, family or his culture? I wanted to capture what had occurred as closely as possible, but sensed that it could not happen in a perfect sense. To get a better sense of it I need to consider the perspective of all the actors involved including myself. The account of what happened would be a co-construction reflective of each of our perspectives about the nature of reality. I wondered about how the actors involved in the episode perceived what was going on. My ability to make sense of what had occurred was interpreted from a stance of multiple realities – from the health technician, the student, and me.

### **Epistemological Assumptions**

Closely related to my assumptions about the nature of reality are epistemological assumptions: How do I know what I know? (Hatch, 2002). My position about knowledge is that it is possible for something to be knowable if it is describable and has a perception or acceptance of believability. I also embrace that, in some cases, knowledge comes as special knowledge because knowing is not based on describing in all cases. The following helps to explain. I am sitting in a chair at my desk. While I cannot describe (as an observer; I cannot see my legs) I can say I know where my legs are –to know is also to be able to tell. In seeing knowledge from this perspective, it is helpful to see myself as a data collection instrument and to acknowledge the complexity (co-construction of it by the researcher and participant) of such to determine what is knowledge.

For a matrix of the concepts related to my stance and the research study framework see Appendix C. This matrix allows for a systematic and organized presentation of assumptions that guided the research process and writing of this report.

### **Role of theory**

In the early stages of this interpretive study the role of theory was prominent. It helped to conceptualize the study design. In addition, theory was later relied on to interpret my observations of behavior and interviews.

### **Caring Theory**

From the beginning of the study, I suspected that the school nurse was acting in caring ways. Looking to caring theories such as Swanson (Potter & Perry, 2005), Watson (2008), and Noddings (2005) provided vocabulary to conceptualize the study, and to link together the activities of a school nurse. My initial data analysis suggested that the caring I observed was what Noddings (2005); Smith, (2004) and Watson (Crigger, 2001) had described in their discourse of caring.

This idea of caring was useful in the interpretive process of what the nurse was doing as described in my fieldnotes and iterated in the transcriptions. Watson describes caring as the interrelationship between health, illness, and human behavior. Her caring theory explains nursing practice as promoting and restoring health and preventing illness (Watson, 2008, p. 31). For Watson, caring is a process consisting of understanding from the perspective of the one cared for, being there, comforting, enabling (informing/explaining) and offering realistic optimism (Watson, 2008; Swanson, 1991). Watson extends caring as central to the nursing profession and ties it to being responsive to a person as a unique individual (Watson; Bednarski, 2009).

Noddings (2005) describes caring as characterized by receptive attention. For her, caring is also characterized by motivational displacement, that is, the ‘carer’ responds to the ‘cared for.’ For Noddings, the final characteristic is that there must be some recognition on the part of the one being ‘cared for.’ In other words, caring is a connection between two people – the ‘carer’ and the ‘cared for’ where each is receptive to the other. As the school nurse participates in caring for children throughout the day the process of caring is evident in each encounter that occurs. She and the children regularly engaged in relationships that connected them as the ‘carer’ and the ‘cared for.’ My fieldnotes repeatedly reflect Ann and the children each as receptive to the other.

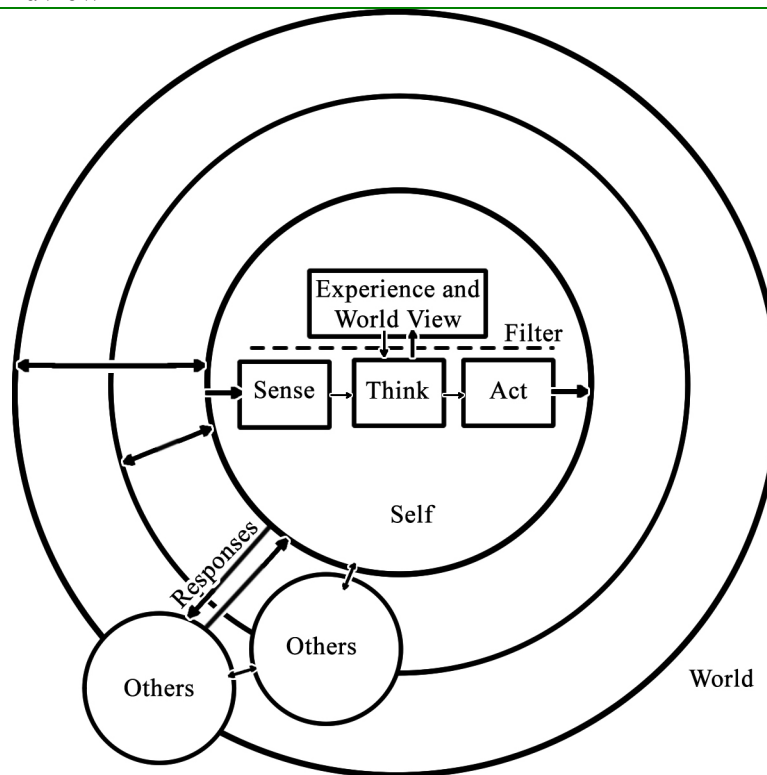
### **Social Learning Theory**

Social learning theory suggests that learning considers the learner’s personal characteristics, their behavior patterns and the environment (Bandura, 1977). It accounts for both internal and external processes associated with learning. Further, it fundamentally relies on role modeling as a central concept (Bandura, 1977); Bastable, 2008; Bahn, 2001). Social learning, succinctly put, explains for us that what one attends to is retained and reproduced as behavior. However, it also has a motivational component that helps to explain the role of culture and society. Bastable suggests that the process of modeling professional nursing behavior influences the adoption of nursing attitudes and actions in the nurses training process. Acknowledging this process, at a most basic level, helps to explain the role of Ann’s professional nurses training, nursing practice and her role as a school nurse.

## **Identity Theory**

To develop a theoretical stance about who Ann is, I also rely on identity theory, as described by Burke and Stets, (2009). Together with the other theories mentioned, identity theory helps to explain, not only social interaction, but also the cognitive process as an internal dynamic process that occurs to respond to social stimuli. Identity theory suggests that the internal cognitive process is conceptualized as what is made of social interaction (Burke & Stets). The internal dynamics of the thinking process can be conceptualized as filtered through prior experience/knowledge and the meaning that the self has attributed to social learning (Sousa, 2002). Past experience and the meaning attributed to identity determines how we respond. Burke & Stets (2009) suggest that, “When we identify the meanings of an identity for an individual, we can predict the meanings of the person’s behavior” (p. 50). In other words, her stance is informed through an understanding of her behavior and the assumption that how she behaves reflects her worldview, that is, what she did reflects how she sees herself (See Figure 1).

Figure 1 – Worldview



Adapted from: Van Sell, S. L. (2002). Nursing: Receding and evolving paradigms. ICUs and Nursing Web Journal, April–June 2002, 1-7.

In addition, the assumption that who we are is a process that is both reciprocal and dynamic (Berns, 2009) is an important consideration. It is reciprocal in that as individuals experience an encounter what produces a response in one usually elicits a response in the other. And, it is dynamic in that changes in society foster encounters that also change over time.

Wolcott (2009) warns about early adoption of theory and the possibility of failing to see what is going on. My attention to his warning is evident in the fieldnotes in that I consistently asked myself: What is going on here? It was useful in my attention to minimizing the use of evaluative terms to describe what occurred and in addressing

theoretical validity. For example, the analysis of the data supported what was going on could be defined as ‘caring’. My analysis suggested that caring theories supported what was described in my fieldnotes (Potter & Perry, 2005; George, 2002; Watson, 2008; Noddings, 2005). Further, Potter & Perry point out that caring drives nursing practice. What I found in my analysis could legitimately be describing what both Watson (Watson, 1997 & 2008; Crigger, 2001) and Noddings (2005) had already described as caring. Caring theory played a significant role in my interpretation of what occurred in the health office.

Looking to other researchers and their work provides a model of how theory use unfolded in this study. Kahn (1997) suggests moving back and forth with theory, informant quotes, and analysis of them. What he advocates is similar to what I described earlier in the cycle of analysis. My adherence to this systematic process accounts for what I did to gain an understanding of health care in a public school.

### **Study Context**

Wiggle Creek Elementary is a Title I School wide Project School that serves 501 students in pre-kindergarten through fifth grade. At Wiggle Creek, 64% of the students represent minority populations. (See Table 1 for race and ethnicity represented at Wiggle Creek and how they were represented in the health office at the time of the study.) Thirty eight percent of the students at Wiggle Creek participate in the English Language Learner Program. The languages spoken by students include: English, Spanish, Vietnamese, Arabic, Chinese, Kurdish, & Nuer. Most of the students (92%) qualify for free or reduced lunch. The average daily attendance rate was 95% (Nebraska Department of Education, 2008-2009).

Table 1 - Race and Ethnicity: comparing school population and visits to the Wiggle Creek Elementary health office

Race/Ethnicity	School Population (%)	Health Office Visits (%)
White (Not Hispanic)	36	7
Black (Not Hispanic)	27	34
Hispanic	19	37
Asian/Pacific Islander	11	0
American Indian/Alaskan Native	7	3

While white students represent the largest percentage of the school population, they do not represent the largest percentage of the health visits that I observed. Hispanic students were the largest percentage of student health visits but rank third in percentage of the school's population. These numbers help to situate the study in a particular context.

### **Access to Study Site**

My access to the research site began with an unscheduled visit to Wiggle Creek Elementary School. My boldness to appear at the school unannounced grew from unsuccessfully contacting the principal through email messaging and phone calls. I was fortunate that the principal was in her office that day. While there, she graciously visited with me about my research. Even while we were visiting informally, she began making phone calls to get clearance to do exactly what I had asked – study what a school nurse does. Once the clearance protocol was determined, the principal made a phone call to the school nurse to ask about the possibility of her visiting with me; she agreed to that, and I was on my way to the health office. In January, I wrote a memo summarizing my visit with Wiggle Creek's School nurse and the health technician. I commented that I felt like I was welcome. I also mentioned that the school nurse and the health technician were kind, caring professionals.

My initial impression was that at this first meeting, the nurse and health technician seemed genuinely pleased to meet with me; they both offered a welcoming handshake. In addition, I was able to obtain both the principal's and the nurse's informal agreement to participate in the study.

Access to conduct the research was a formal process that included obtaining the district's institutional permission to conduct research and the university Institutional Review Board approval. After obtaining these approvals, three participants were selected and contacted formally to invite them to participate.

### **Participant Selection**

I purposely selected Wiggle Creek Elementary because of student demographics. This setting is appropriate for the study of a school nurse that serves a diverse population. The study participants were selected using purposeful sampling. Since I intentionally selected Wiggle Creek Elementary as the study site because of the student diversity, it followed that the study participants would be this school's principal, school nurse and the health technician. These three individuals were each given a description of the study, invited to participate, and their informed consent was obtained.

The primary informant is Ann the school nurse at Wiggle Creek Elementary School. In chapter four she is introduced formally. My impression was that conversation came easy for her. This characteristic was invaluable to create the account that I sought.

Since the nurse is not isolated in the selected site, the necessity existed to give attention to others that she interacted with. These individuals included the students, school staff, parents, and community professionals that provide health care for the Wiggle Creek Community. To describe what the nurse did, those she interacted with are



mentioned in order to give the full account. To give them a voice in the encounter, they were assigned pseudonyms, and what occurred was fictionalized to maintain confidentiality. Enlisting the two other informants (health technician and school principal) provided the means to give attention to the particular from a different perspective, and to give an account of the “broader context in which an individual lives and works, and the various ways in which circumstances which appear to be external to [the nurses] role may actually exert considerable impact” (Wolcott, 2003, p. xv). The school principal’s perspective is representative of an educator’s stance on health care in an education setting. The health technician contributed to seeing what occurred from someone else other than the school nurse.

As the principal investigator, I provided all participants (school nurse, health technician, and school principal) with a copy of the consent form to read, and then discussed with them their participation in the study. Signed consent was obtained prior to the start of data collection, and a copy of it was given to the participant. The consent form and the conversation that I had with informants prior to participation made it clear what was expected – their participation was voluntary and that there were no known risks associated with their participation in the study.

### **Data Gathering Tools**

This study is framed using an ethnographic approach and relies on the research tools that Spradley (1979) and Emerson, Fretz, & Shaw (1995) recommend. Observations and interviews took place on weekly occasions between January 3, 2011 and January 3, 2012. The location and identification of the informants has been kept anonymous through the use of assigned pseudonyms.

After observing, I immediately read my on site writing and added additional text to capture more of the details to describe what had occurred. These fieldnotes were typed and then analyzed using open coding and focused coding to develop emergent themes. Memos were written that reflected my initial understanding and included questions related to what seemed unclear. Analysis of the interviews followed a similar process. Transcriptions of the audio taped interviews were done shortly after the recording, followed by coding, and theme analysis (Spradley, 1979). Again, as in fieldnote analysis, I wrote memos that functioned to guide my next visit to the study site. Reliance on this process, as mentioned above, was particularly assistive in identifying further questions to ask of my participants and improved getting to the participant's perspective (i.e., what it was she did).

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**Figure 2 – Data Analysis Spiral**

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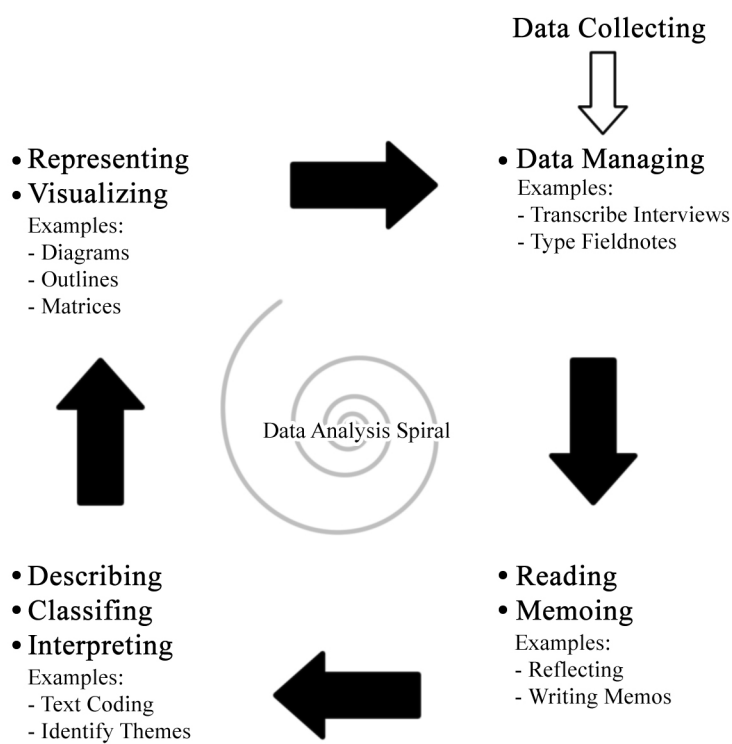


Figure 2 is a conceptual visualization of the research process that occurred to create the account of what a school nurse does. Conceptualizing it as a spiral captures the ongoing nature of data collecting, analysis, and reporting. It also accounts for the comparison of incidents and development of patterns of nursing practice and its relationship to the concept of caring and the nuanced ways it unfolded in a public school health office.

This report utilizes a broad approach recommended by Geertz (1973) and frequent use of selected fieldnotes to provide thick description as he described it. I relied on my informants' words to create the account of what a particular school nurse does.

Reflexivity, concerns with validity, and the tools of an ethnographic approach facilitated the management of researcher subjectivity and bias.

### **Confidentiality**

On occasion, encounters with the nurse were categorized as confidential and were stricken from the written record to protect privacy. As the principal investigator I had an agreement with the school nurse that no confidential information would be recorded either through observation or as text in interviews. The nurse determined that confidential information was not collected as data for this study. The written material (text) including fieldnotes and interview transcriptions were reviewed for confidential information.

Confidential information has been stricken from the data and is not in the research report. As a result, the possibility exists that the data might be skewed because of deletions – it is a reality of what can occur. The clear goal of gathering data that reflects the nurse's perspective (not that of the individuals she encountered) was a planned research strategy to eliminate the collecting of confidential information.

### **Credibility/trustworthiness**

The strategies to assess the “accuracy” of the study findings were prolonged engagement in the field (observations and interviews occurred on weekly occasions between January 3, 2011 and January 3, 2012), use of detailed thick description, member checking, triangulation (sources, theories, qualitative research tools), and researcher reflexivity. My prolonged engagement at the study site helped to build trust with the participant, to learn the culture and to reflect on patterns of behavior (Creswell, 2007). The use of thick description allows the reader of this report to make decisions about generalizability and/or transferability. The inclusion of detailed accounts that the participant described helps readers to transfer information from this setting to other settings (Creswell).

The scope of the work of a school nurse, either as an individual or in concert with others is extensive at multiple levels – school, district and community. The study’s framework, an ethnographic approach, guided what was generated as knowledge. This knowledge is useful in understanding what a school nurse does in a public school and how that improves educational outcome.

### **Researcher Reflexivity**

Articulating researcher reflexivity early on in the written report establishes that I am conscious that values and personal experience were brought to the study. My perspective is re-enforced in my use of a medical lens and educator lens to focus on what I described. However, personal bias might also be seen as a strength. Interestingly, Corbin & Strauss (2008) suggest that personal experience may be a valuable resource in getting the participant’s story right. My experience as a medical care provider and

educator broadened my understanding of how others and I construct knowledge. The idea of an interpretive process implies a researcher vantage point and the subjectivity that such a process is likely to entail. Another researcher might interpret the findings in different ways.

### **Study Limitations**

There were, however, some surprises and unique findings that may inform researchers and engender further research. The use of an ethnographic approach to frame this inquiry using purposeful sampling provides for an in-depth study of a particular nurse in a particular context. However, choosing to use purposeful sampling, limits the generalizability of the findings.

Assessment of learning health information as result of teaching is a concern. It is not within the scope of this study to follow-up on the outcome of learning directly. Prominent throughout the data is face-to-face teaching, and what occurred in the health office as a result of it. The focus was directed at what the nurse did in all encounters that got described. For example, I can only base assumptions of “prepared to learn in the classroom” from the perspective of the child while they were in the health office. It reflects my assumptions about their body language as they responded to Ann’s humor, or a response such as “left with a quickened step” or on occasion skipping out of the room.

Maughan (2003) questioned the effectiveness of school nurses on education outcome. Her study confirms what I too am concerned about: How do we know if what Ann does has an effect on education outcome? Wiggle Creek has 501 Students, with a 95% daily attendance rate (NDE, 2008-2009). What effect does her role have on this rate? The evidence is likely to suggest that of a whole school effort where the nurse

functions as ancillary to directly educating about health and supporting learning through addressing health issues. While her educating is prominent and her medical care is standard nursing practice, the effect of both is directed towards keeping kids in their classroom seats.

Further study is needed to explore the effect of care provided by the school nurse. Does the child have an improved capacity to learn once they return to their classroom? Future research can validate the findings of health care at school and its influence on the capacity to learn. Using other nurses and schools as participants and using other research methods this relationship can be better understood. For example, teachers journaling with specific questions or questions asked after a nurse visit may be effective methods of exploring the relationship between the nurse's care and the child's learning after a health office visit.

This study did not explore the extent or affect of role modeling on the students' ability to develop caring relationships. Ann modeled caring and engaged children in caring relationships. Future research can validate the extent of the affect of her modeling caring and the role it plays in a public school.

### **Definition of Terms**

The conceptualization of *health* is central to this inquiry. It is defined broadly as a state of overall well being, including not only physical health, but also social and mental health. And, it is understood as a relative term reflective of an individual's beliefs, ideas and attitudes about well being. Potter and Perry (2005) enlighten that nursing practice recognizes that health may be defined in terms of the individual's health knowledge. Beliefs and ideas about health are rooted in culture, a notion that defining health is not an

isolated process occurring within the person, but rather an interaction between the person and his/her environment, where each continually impacts and changes the other (Welsh & Murphy, 2003).

*Caring* is a frequently used term in the study. It is understood from two perspectives: 1) Jean Watson's (1997) theory of caring in the professional practice of nursing, and 2) Nel Noddings' (2005) theory of caring as a universal social process comprised of attentiveness, engagement, and acting on the behalf of another (Crigger, 2001). Both perspectives are useful to understand what the school nurse does. Defining it in this way helps to conceptualize the essence of Ann in her role as the school nurse. Caring is at the heart of nursing practice "to work with people in a respectful and therapeutic way" (Potter & Perry, 2005, p. 108). The notion of caring is prominent in the descriptions of Ann providing for the health needs of students, staff and parents in this particular community.

Caring conceptualized as giving attention to and being receptive to the needs of others in a special way while invoking it as a procedural system to care (Watson, 1997) and a universal social process to care on the behalf of others (Noddings, 2005), becomes more complex when viewed as woven into the fabric created out of other threads (e.g., role, identity, and perspective).

*Identity* focuses on the set of meanings that define Ann as a school nurse in her occupying the role of teacher and medical caregiver. Burke and Stets (2009) assert that identity is a "set of meanings that define who one is when one is an occupant of a particular role in society" (p.3). Burke & Reitzes (1981) suggest that it is "a social product... [that] is formed in particular situations and organized hierarchically... [and] is

symbolic and reflexive in character” (p. 84).

*Role* is defined using the dictionary definition. It encompasses the socially expected behavior patterns usually determined by an individual's status in a particular society (role, 2011).

*Medical caregiver and health care provider* are used interchangeably to refer to an act of providing direct medical care. For this inquiry, when used in the context of an elementary school it is associated with the school nurse and the status she assumes as an expert in identification, prevention and treatment of illness or injury (Urdang, 1975).

*Teacher* is defined broadly using both a philosophical and dictionary definitions. It is defined as a particular way of speaking engendering discourse that connects the worlds, of both the teacher and learner. The study relies on the assumption that a relational and interactive encounter occurs and requires “dialogue, give and take, back and forth. Requiring a thinking and caring person.” (Ayers, 2001, p.17). Furthermore, implicit in this definition is that roles such as communicator and team player are valued and that she engages in a caring relationship with those individuals that she encounters.

*Learning* is a term connected with teaching. It is the result of the relational and interactive encounters that the nurse and the children regularly engage. It also assumes that it is “lasting, meaningful, [and, most importantly, it leads] to further growth and learning” (p. 3, Ayers, 2001).



## **Chapter Four**

### **Study Participant: School Nurse**

#### **Introduction**

“Health office. Ann Linner, R.N., speaking.” These were the words that Ann had clearly articulated into the receiver of the black desk phone; it was her greeting, and it serves as a concise description of how she had wanted the caller to see her. Ann frequently answered the phone with these words; they serve to introduce how she sees herself: a professional nurse in an educational context.

Contrary to her clarity when answering the phone is the ambiguity of how the children saw her. This was evident from what they said. Children did not specifically address Ann as the nurse, but instead addressed her in ways that were more familiar to them. For example, on one occasion when Ann had stepped out of the room briefly a child had specifically asked, “Where is the other teacher?” On another occasion a child had called her doctor, a reference to a medical profession authority.

Ann believed that the children saw her playing multiple roles. I noticed this too. Early in the study, she told me that she preferred to be called Miss Ann. ‘Miss Ann’ is a more endearing term, one that has a southern tradition that carries both the notion of respect and familiarity. Miss Ann invokes images of a kind, gentle, and respected person. Plus, it hints that she views herself as friendly and as one that serves another.

The sense that Ann wanted to be known formally through her professional title and informally using her first name suggests that her understanding of her multi-faceted role as a health care professional in a public school is complex and extends an invitation to examine the study data to understand who she is.

This chapter introduces Ann's perspective and provides further insight about who she is. To construct a conceptual framework of her perspective, as personal and as professional, I rely on two theories: 1) social learning theory and 2) identity theory. These theories model the relationship between the individual and their social context, and they provide the framework to understand Ann's observed behavior and the stories she shared to enlighten about her personal and professional stance.

### **Participant's Stance**

The study data documents her behavior to help build a case for the stance that she held, and reflects personal and professional associated meanings and expectations she had of herself (Burke & Stets, 2009). Examining her multiple roles through both a personal lens and a professional lens merits separate mention because the data as stories, behaviors and her held beliefs characterizes who she is (i.e., Ann's observed behavior, her iterations of past experiences and her reflections of held beliefs are found there). Using this process provides for her identity to emerge as actions and action choices that get enacted and indirectly reflect identity (Burke & Stets). Simply put, I rely on her comments plus any observable natural social interactions to understand her vantage point.

### **Personal Stance**

When there was time in between caring for the children, Ann described a variety of adult roles that she regularly enacted. For example, she shared about her role as a spouse, parent and grandparent. She also described a time prior to her nursing career when she was a day-care provider. Interestingly, all of these roles require characteristics that are also desirable of a school nurse.

In my time observing, Ann spent considerable time communicating. She regularly enlisted listening and speaking skills to directly relate to others health information. Her regular engagement with others in relationship building behavior is salient throughout the data. This characteristic is reflected in her assessment of her responses and her perception of how others perceived her and her adjustment to it. Support for this is found repeatedly in communication with others to show interest in the experiences of others (children arriving for health care) and her responding appropriately. Drawing from this and the assumption of her other salient characteristics such as caring attitude, intuitive, calm disposition, and relationship builder provide support for making claims about Ann's personal perspective.

**Caring attitude.** In a fieldnote in early February, I described Ann's caring attitude that was noticed in the face-to-face encounters that occurred with children. It characterized the recurring process of caring, (i.e., her giving attention to and being receptive to the needs of children in a special way). For example, in January, she was waking up children that had been too tired to stay awake in their classroom. She walked to the first cot with the sleeping kindergartner on it. "Oh, my little 'dimple' darling. Time to wake up. Come let's get a drink. Can you find your way back to class? Go, go, go," she had said as she gestured that Kate should leave the room. Once she was out of the room Ann walked around the wooden divider and stepped to the second cot. Calling her name, she awakened the third grader, Jane, to ask her if she wanted to wash her face. Jane shook her head while she stretched, and asked her, "Can you make it back to class?" This time Jane nodded her head in agreement, and she walked out the health office door. Once Jane was out the room, Ann walked over to the third cot to waken the remaining

sleeping child. She whispered his name, several times to awaken him. Then Ann said, “Billy, do you want to wash your face? Can you make it back to class?” He nodded in agreement, and left for his classroom.

The affectionate “my little ‘dimple’ darling” phrase suggests caring that is based on a relationship that had been established, one that was nurturing in nature. She had also positioned herself beside each child as she woke them; it too adds to a caring attitude that was present as she cared for the children. It was natural for her to do it this way. On other occasions, she frequently held their hands or would put her arm around them while she assessed the physical complaint for why they had come to her to receive care. Her reassuring presence as she looked at their eyes no doubt were also important to her success in other roles, such as spouse, parent, and care giver in a day care, that were regularly observed to characterize her as a caring person.

**Intuitive.** Ann frequently relied on her intuition and had to make quick use of it to respond (creative problem solver) to the children she encountered. In late April, she told me an interesting story that illustrates this intuitive process. Several years ago a little boy had found himself in her office on a gray stormy day. It was the kind of day that was filled with frequent sounds of thunder and flashes of lightening. In fact, he had been to the health office several times already that day. While her assessment of him did not have any of the indicators for sending him home, she asked his mother to come to pick him up. When she talked with mom, she found out that he was deathly afraid of storms and the accompanying thunder and lightening. She described what she did as ‘winging it’. Her ability to quickly respond resulted in her constructing a lucky rabbits foot to keep

him safe. She recalled asking him, “Do you have a lucky bunny foot?” His response was to say nothing.

While she was trying to calm him, she quickly constructed one out the materials she could think of that would provide comfort and courage. Her quickly constructed ‘lucky bunny foot’ consisted of four cotton balls, a gauze pad and paper tape; they were lined up then rolled up in the gauze and taped together. Then, just as she finished they had an usually loud thunder. He quickly grabbed the cotton bunny foot. And, to both their surprise, the skies cleared and they noticed the sunshine. She remembered the little boys eyes getting so big. Months later she received a phone call from the little boy’s mom asking her to make another one. Apparently, Mom had washed it, which ruined it.

Attending to a child’s fear of thunderstorms is not a typical complaint a nurse might encounter, she nevertheless had been able to problem solve using a common sense approach, something I noticed regularly in my fieldnotes. For her, the change in the child was striking. She said, “Before the bunny foot he would always have to be held when it was stormy. The bunny foot had taken care of that.” It had provided the child with the means to comfort himself. She had been able to supply something tangible that held associated comfort that she had taught him to believe in.

**Calm demeanor and use of humor.** Occasionally, the health office environment was ripe for behavior that created chaos and stress. When this occurred, I noticed that Ann maintained a friendly countenance and calm demeanor. On one stressful day, she had simply introduced me to a serious incident as, “It has been a little crazy today.” For her the reference to “crazy” was more about the extra time it had taken her to investigate or assess an emergency incident (one with possible injuries) and the documentation of it.

Her assessment was that the incident had taken most of her time that morning. In a memo, related to the incident I noted that I did not sense any urgency. Ann had seemed calm in caring for the child, notifying parents, and communicating what was necessary and documenting the incident for the health record. This pattern, no matter what situation was presented to her, was consistent, she remained calm, caring and focused on responding to whom she encountered at the time.

On some occasions, especially chaotic ones, she often would use humor to manage the situation. For example, a student had entered the health office complaining that his chest hurt. Then, after making a careful assessment of them she announced, “You sound GOOD. I think you are going to live.” Throughout the information gathering and assessment she had built a relationship with the child, gave them the assurance that they were healthy. And, her use of humor distracted the child’s thinking through the words, “you are going to live;” it brought a smile to the child’s face. For her, the use of humor let the children see her “crazy side.” It was often useful to distract them or shift their focus from that of illness or pain to that of they were healthy.

In April I saw the ‘crazy’ side of Ann. She was seated at her desk, leaning back in her chair with her arms folded. A fourth grade child, Don entered the room. She talked softly to him to determine that nothing was physically wrong with his eye. “Oh my gosh it didn’t fall out (reference to his eye). You are going to be all right.” They laughed, then they talked and laughed some more, then he was ready to go back to class.

The use of humor had worked because she knew the student well, that is, she knew his first and last name, his parents, their family situation, and the frequency of him visiting the health office. To her, it made sense to create a relaxed familiar atmosphere,

one that was accepting of joking around. I noticed she did not do that with every child; especially with children she did not know their name. For her humor was a valuable tool; useful to change the child's belief from that they were ill and enacting illness related behavior to that they were healthy. Her affinity towards positivity made the use of humor a recurring behavior she naturally relied on. However, she would carefully assess the situation to be sure the humor was appropriate.

**De-escalating tense situations.** Another time, an older male student had arrived in the room escorted by an administrator. Her face and body language confirmed an uncompromising demeanor reflective of a tense situation. She described to Ann the situation and the reason he had been brought to her. Upon arrival in the health office, the student was told by the administrator to have a seat, a chair that she pulled out for him to sit on. With that, she turned and left the room. Ann stood next to her desk to talk to the student. What happened next was not surprising – she used humor to respectfully de-escalate the tension. I noticed his smile (evidence that he was calming down). Ann's approach to his defiance was first to de-escalate the situation. A simple humorous phrase as, "If she wants me to sit on him," gave her the opportunity to further communicate with the student and address the need that he had been brought into the room for her to assess.

While I never witnessed her reacting to stressful situations in negative ways, I did notice that stress did affect her. In late August, I saw Ann's desk strewn with a variety of things. Purple post-it notes attached to several of the 8x11 papers cluttered her desk. A notebook was open. Several pens, pencils and highlighters were left beside the open

notebook. Her desk basket was overflowing with papers, and her desk chair was left pushed away from the desk.

Usually her desk was left neat and everything in its place for when she first arrived. My assumption was that Friday had been a busy day, and she had probably left hurriedly not having time to tidy up her desk. When she arrived that day she too noticed her messy desk. She explained that her desk was usually left at the end of the day with what she needs to do first when she arrives the next school day. However, on Friday she had not had time to do any organizing because of a 2:30 p.m. meeting that had gone on long after the usual one hour expected. She and her husband had had plans for the evening (meeting friends) and so she had to excuse herself from the meeting and rush to meet her husband. In this instance the meeting she had been attending was personally stressful because of her deep concerns about problems with getting adequate care for a particular child that was complicated by the parents unwillingness to cooperate to get that care.

**Relationship builder.** The study also suggests that her role as a relationship builder (friend used broadly) was salient in my fieldnotes. To build relationships she also utilized traits such as communicator, sympathetic, reliable, generous, and a source of help. On a cold rainy day, in the spring, I noticed these traits as our informal conversation turned to what to have for lunch. We discussed a particular restaurant's menu and casually mentioned our favorite items. Ann contributed, "I feel like having some of their soup." Beginning with that comment she began to ask others to join her for lunch. She phoned Joan to see if they (office workers) wanted to join her, and asked what they wanted to order. Then she asked me "Would you like to join us?" Shortly, Joan, the



school secretary, arrived with a list of office staff choices for lunch and their money.

Beth gave Ann her order; Ann insisted on paying for hers. She had in a short time span organized lunch on a day that eating together would be enjoyable for everyone.

Serendipitous encounters such as the one above organizing lunch and her generosity (e.g., monetary and social interaction) enlighten about Ann too.

I noticed her use of her out of pocket money for such things as rewards for compliance with daily medication or buying deodorant so all children in their sex education class would each have their own supply. She explained her situation this way: Nurses like teachers each get \$250 dollars at the beginning of the year to spend on additional wants outside of their regular orders. For her on occasion the dollar amount had not covered the cost of unplanned necessities. Sometimes it was for Friday treats, other times it was for a hair dryer to dry clothing after a wet recess when extra clothing had run low, or for supplementing the free supplies she received from benefactors.

Ann's personal perspective was reflected in what she enacted to serve as Wiggle Creek's school nurse. The study supports that she regularly acted in ways that characterized intuition (quick to solve problems effectively); calming disposition regularly utilizing her capacity to de-escalate tense situations through the use of social interaction skills (used humor; communication; self- monitoring and adjustment) along with her personal relationships. These pieces of information make up the mosaic that reflect her personal perspective.

### **Professional Stance**

To describe her professional perspective, her everyday philosophical frame of reference of why she sees it this way, I return to the study data and view it using a

professional lens. Again, the convergence of Ann's observed behavior, her iterations of past experiences and her reflections of held beliefs create a mosaic that hint at her stance. Pieced together they help to understand her professional vantage point – her ontological and epistemological assumptions that undergird what got described as professional nursing practice enacted at Wiggle Creek Elementary.

Potter & Perry (2002) suggest that the nursing profession is closely tied to desirable character traits expected in an educational setting. Nurses deliver “care artfully with compassion, caring and respect for each person’s dignity and personhood” (Potter & Perry, 2002, p. 2). Teachers strive to do that too. She was skilled at social interaction; it is prominent in the study data as observation and conversation. It is not surprising that interaction was tightly woven into her nursing practice in the Wiggle Creek Elementary Health Office. What occurred illustrated her ability to socially interact with compassion, caring and respect. For example, in mid-November, she helped a child learn to blow his nose. When Jerry arrived, Ann drew him close to her to have a face-to-face conversation about his tummy, as she did that she noticed that he needed to blow his nose. “Your nose might be causing your upset tummy. You need to blow it out so it doesn’t go into your tummy,” she told him. She watched him blow his nose; not being satisfied with his effort she said, “Let me hold the tissue and you blow. Stop sniffing it just goes into your stomach.” Three tissues later he was done blowing his nose; he was sent back to class.

In this instance, the child had come to the health office complaining of a tummy ache; Ann would help him learn to blow his nose. This encounter illustrates how learning takes place that teaches a child to manage a health behavior. Even though the child was capable of blowing his nose, she had interacted with him as a professional health care

provider to directly instruct him to do that in a caring, compassionate and respectful manner. Perhaps the learning would be lasting, and it would keep him in class throughout the duration of most upper respiratory illnesses, such as the common cold.

Ann's prior experience as a pediatric nurse functioned to identify her knowledge of children not only physically, but socially and mentally too. Her 19 plus years of experience enhance her knowledge of the health of children. Her worldview mediated what she did, but so did what the district expected of her. For example, Ann frequently iterated that she was seen as the medical expert in the building. She also told me that she attended staff meetings as the medical expert and would gather health related information that she had documented about specific children and take that information with her to meetings. I observed this as well. At meetings that I attended with her, she contributed only what she had documented.

Ann systematically collected data on a daily basis, and she often relied on this data to guide systematic procedures and protocol, and to construct knowledge from her observation of patterns that contributed to low level statistics (e.g., frequency counting) that nurses are required to collect to meet the expectations of the role of school nurse. For example, on a regular basis, as she encountered children in her office she would immediately refer to the child's health record; it helped with such things as establishing frequency of visits, and general health status that had been gathered from yearly screenings. The technology for health records that she utilized provided Ann with easy access to this information. On one occasion after a child had established a pattern of daily frequenting the health office, a quick review of the child's health record, Ann exclaimed, "Good gravy how many times have you been here?" A reference to her

noticing that this child had been in to the health office many times, and that she would respond to that.

How Ann had wanted to provide health care for children and what got done clearly were representative of what her district required of school nurses. In particular, her district's website brings to the fore specific commitments and the prescribed experiences that are expected of a school nurse. Referring to this list of prescribed activities (health screenings, control communicable diseases, emergency preparedness, teaching health related curriculum and management of chronic health conditions) opens speculation of how what we do reflects who we are and how we see the world. Relatedly, it also sets up consideration of the relation between expected role and how we actually conduct ourselves.

Emerging from the study data were the following behavior themes that characterize her professional stance: child advocate, education focused, autonomy, case manager and nursing process. The themes are prominent within her enactment of the roles the district expected of her and what she expected of herself as a professional nurse; my fieldnotes reflect that. On the pages that follow, I discuss her observed behavior and the stories she told. What is offered in the end is a mosaic, a reflection of who Ann is.

**Health screening.** Lincoln Public Schools school nurses were expected to provide screening for height, weight, vision, and hearing. Dental health screening was required of all children that had not been screened by a dental health care provider in the past year. The act of screening all children enrolled at Wiggle Creek Elementary afforded them the opportunity to participate in health care at the primary preventative level of health care delivery and access to it. It was at this time health concerns were

noted and followed up. The interaction that occurred as a result of nursing practice were central in addressing holistic health needs of the child (Potter & Perry, 2009). Ann and the health technician, Beth enacted the nursing process as they completed the required health screening. These activities showcase Ann's experiences with data collection, systematic procedures and protocol.

In the second week of the fall semester, I had the privilege of observing her screening pre-kindergarten age children enrolled in the districts Early Childhood Infant Toddler Educare (EXCITE). When I arrived, I saw Ann with two three year-old males. "Try to remember these words," she had said. Travis and Steve were situated close to her and to the eye chart. To introduce them to the eye chart symbols, she pointed to each symbol along with saying its name. She repeated this process twice. Using her white-glove pointer, she pointed and asked, "What's that?" Beth stood by Travis to assist with him covering one eye. The other eye was screened repeating the procedure, then it was Steve's turn; he too completed the eye screening, as did Travis. Screening for hearing was next. She brought both boys over to the audiometer. Ann said, "I've got another game. You say 'hear it' when you hear the sound." She let them both listen without the headphones. Travis said, "I hear it." Steve just smiled.

Both children appeared engaged in playing her 'game'; she had introduced it that way the day before when she visited their classroom to educate them about the 'game' they would play in her room. She also carefully watched both boys and their reaction to the sound. Combined with the child's words "I hear it" and their facial expression she would make the assessment of their hearing. For the first child's hearing screen, I hear

him say 'I hear it several times'. To each of his responses she smiled big and said "Good job."

Later she confided more details about the vision and hearing screening, commenting that, "You have to listen to how the child pronounces the name to determine if they see it right. Also you have to watch their faces and listen to their response to hearing the sound to screen for hearing problems."

The study also enlightens about Ann's role in advocating for children especially when it is defined as serving the needs of children (Potter & Perry, 2009). For example, to weigh and measure height the children's shoes must be removed. When two more children arrived in the health office, Beth asked them to take off their shoes for height and weight measurements. Once that was completed, Ann watched while they both attempted to put their shoes on. She noticed Buddy attempting to put his on without untying them, and then trying to walk to the eye chart around the corner with his feet half in each of the shoes. To help him, she untied them and said, "Push!" He did. Then she tied his shoes and guided him to stand beside Beth for her to listen to them verbalize the eye chart symbols. The vision screening, after meeting their needs to verbalize the symbols began again, as it did with the previous two children. Buddy's labels were difficult to distinguish. She had him repeat two more times. Sam, with obvious cognitive disabilities, was sitting on her lap. The assessment was made that Buddy had failed the vision screen and would be re-screened. They agreed that Sam could not do the eye chart at this time, and he would be screened at another time as well.

The children were always complimented for their efforts with "Good job, good job," and I noticed smiles of joy from both Beth and Ann after each response. More

importantly, I noticed Ann's effort to make adaptations to the process to adequately assess the health status of each screening. While her actions enlighten about her activities to advocate at a basic level for each child, her experience as a mom, day-care provider, and pediatric nurse also influenced what she did related to adapting case-by-case to provide screening for the children to obtain an accurate assessment of health.

Further, Ann acting in the role of a child advocate and case manager were also salient in my fieldnotes. In a formal interview, Ann told this story of one child not wanting to wear her glasses:

I said, "You know your teacher is so worried that you aren't doing well with your class work. She imitates the child: "But I don't like my glasses."

I told her that's okay but when you are in school doing class work you have to wear your glasses. You don't have to wear them anywhere else if mom is okay with that. But here you have to wear them. I'm pretty firm; I'm using a nice voice here, but with her my voice gets deep and I'm firm. Beth walked her back to her classroom, and told her teacher that she has glasses and she needs to be wearing them. Now her teacher knows she has glasses, and they are in her backpack. (5/23/11)

In this instance, Ann and Beth had both advocated for this child and had served in the capacity of case manager. She understood that the child did not want to wear them. She persisted anyway. I noted in my fieldnotes that Ann was vigilante about asking children where their glasses were if they arrived in the health office without them. And, she mentioned that she would often investigate where glasses were if she did not find the child wearing them. Frequently, the need for glasses was detected in the annual vision

screening. Because of that she had first hand knowledge of children's vision status and their need for glasses. It had helped her to advocate for them even when there was resistance by the child.

**Control communicable diseases.** Another task that Ann was expected to accomplish, as Wiggle Creek's School nurse, was to control the spread of communicable diseases. The school nurse was required to do this in two ways: 1) monitor immunization compliance, and 2) follow district criteria for sending children home from school.

**Immunizations.** The state required specific immunizations (an effective means to prevent the spread of disease) to attend public schools. This requirement provided for a significant amount of data collected in the fall semester. In the year the study was completed the state had required that all students age five and older who have not had chicken pox receive a second dose of chicken pox vaccine or be excluded from attending school (Health Services, 2010). Her activities to advocate for children and to manage each case of non-compliance had taken a considerable amount of time.

Because all children and their families had received notification from her that her records showed that they had not had chicken pox nor had they received the second vaccine their were no excuses for noncompliance. At least that had been how she felt. Yet she would send another notification to parents of exclusion and the date that would occur.

When I arrived to observe, I made it a habit to ask what she was working on. In September, she had informed that today she was "calling everyone, leaving messages, and waiting for return calls." She described that at a minimum a child must have made an appointment with the Health Department or any medical clinic to receive the required



vaccine. Then the parent was responsible for calling to tell her that their child had been immunized.

It was important to her that no child be excluded from school because of not receiving the “varicella second shot.” She repeatedly called everyone that had not complied, often leaving messages because no one answered the phone. Then she would wait for parents to return her call. Simply put, she would continue her effort until all were in compliance with state immunization laws.

On another occasion she had iterated, “We all know how well that worked out.” Her reference to the number of children not in compliance for the vaccine by the state mandated date. In some cases it had simply not been enough. On exclusion day she would send a note home with any child not in compliance or without an appointment to receive the vaccine not to come to school tomorrow. She had drafted the note to only use simple sentences, and had highlighted in orange just the important information.

Asking a child to not come to school was personally frustrating for her, especially since she had begun working to notify parents nearly a year ago. Add to that, a year ago the local nurses had voiced their opinion that many, many children had not received this vaccine nor had they had the disease. Sensing that as a nurse she had not been heard, frustrated her with the state health department too, and bluntly put it this way “They were caught with their pants down.” Her reference to her frustration and as a lack of effort by health department officials to do their part in getting the 100% compliance that the nurses had worked towards.

***District exclusion criteria.*** The nursing caregiver role, to make assessments about the possibility of a child having a communicable disease, followed district required

exclusion protocol; it protected the other children from being exposed to germs that can spread quickly. To control the spread of contagious diseases that did not have a required immunization she would call on her medical knowledge of various diseases. One early April morning she had received a phone call from a parent that thought her child had fifth disease, and she wanted Ann to look at the child's rash. Ann was concerned that the rash might be from bacteria. She explained it this way: "If a rash is not an obvious contact rash, which we ask the child for example to take off a necklace, wash the skin, and ask them to return to have a look again at it, we are to send them home. To return, the child will need a doctor's note."

Sometimes the assessment of a communicable disease is not clear-cut, and Ann was left to make guesses in advocating for the child. One day in early May, she had a child resting on a cot for further observation. She had confided to me that, "I can't figure this one out." She had been thinking about where he lived. If he had had one of the symptoms that required him be sent home, the parents would be called to pick him up. If they refused to pick him up, as a last resort either she or the principal would take them home. This always seemed to frustrate Ann. She iterated that sometimes parents declining to pick up a child is part of their story of having others do things for them, and added, "I pull the police card, then they can get them home. It is surprising how they suddenly can find a way to pick up the child." Sending children home when she suspected that they may be infected with germs that are communicable was one strategy she utilized to control the spread of germs.

### **Teaching Health Related Curriculum**

Simply put, the staff at Wiggle Creek Elementary School relied on Ann to teach formally health related curriculum such as growth and development and basic first aid training. Her efforts to do that reflected the autonomy she assumed as a teacher. She was reasonably independent and self-governing in decision making when it came to formal teaching practice. However, her efforts on when to teach were coordinated with other nurses because the curriculum was shared. Together the district nurses would plan the district wide teaching and share the teaching materials for the growth and development curriculum.

Ann's teaching style was that of expert at the front of the room, yet she did not model the "the sage on the stage" format completely, but also followed a constructivist approach format in which the children knew their questions would be welcome and the discussion of them would likely take place. And, she always used props and scenarios that related to her audience and the everyday events they might be a witness to. For example, her antics (she admitted that she had worked herself up and was sweating) such as using a loud voice, alternating with a soft voice while demonstrating how to walk and talk with an excited person to slow them down, were a frequent teaching tool. In basic aid training (BAT) she regularly asked for the fourth grade children to share what they had done to help with emergencies. When they told a story that revealed that they had helped in a meaningful way, she praised them and tied it to the curriculum she had been expected to teach.

Teaching the growth and development curriculum went similarly. During the last week of school, in a fourth grade classroom, she began her teaching with a video, when it

was finished, she moved to the front of the room. After pushing the TV cart away from the board, her conversation with the fourth grade girls began with asking questions. The first question was related to mood swings. To answer the question, she added a scenario that caused the girls to giggle. After talking about mood swings for a while, she asked, “So what else can happen? Some physical changes we go through – on your arms and on your legs (girls guess hair). Ya, you get the hair going. And, in the US, most of us end up shaving our legs and underarms. Not every culture does that. So don’t be surprised if you find some people that don’t do that. OKAY. And, it is all right. There is nothing in the law book that says that you have to shave your legs or underarms.” For her, an education focus came naturally. It was natural for her to include strategies that took into account culture and social learning that had passed from generation to generation.

Early in the study she had iterated that, “What we do is make sure kids are healthy so they can academically perform.” To prevent the spread of disease, she regularly educated about washing hands with soap and plenty of water. She also regularly taught children to keep their shoes tied, and when their tummies hurt she would ask about what food they had eaten. In late fall after Thanksgiving, in her assessment of a child complaining of his tummy hurting she had quizzed him about the food he had eaten for Thanksgiving Dinner, specifically questioning him about the vegetables he had eaten. Simply put, she utilized opportunities to teach health that would be meaningful at a particular moment in time.

An education focus, in almost all of the encounters she found herself in was in the role of explainer. To meet physical needs and formal teaching in the classroom, there was usually a concept, fact, or action that needed to be explained. She was skilled at that.

The role of communicator as professional nurse and as an individual was important in her role as educator too.

Not only did she educate the children but she also educated parents too. She had iterated that the amount of health educating she would do depended on “if the kids are doing well or not.” To illustrate her point she told about a child with asthma. “I had to tell him no, no, no. You have to do it this way. (She demonstrated using her hands how to give a treatment with the inhaler). When a child insists on following what a parent has told them to do I have to call mom and ask if they want to come in. Sometimes they do and sometimes they do not. But, I do a lot of teaching over the phone with the parents. Especially if parents and their child think they are doing things right and they are not.”

Her teaching methods, ones that matched the children’s abilities, enlighten about her education focus as it occurred in planned and formal contexts and in contexts to educate that were informal and an unplanned. Her focus was always on her goal of keeping the children in the classroom healthy and capable of learning.

### **Emergency Preparedness**

A fourth task that Ann was expected to accomplish, as Wiggle Creek’s School Nurse was to provide leadership and management in all phases of emergency preparedness. As the only licensed health care provider in the building it was her responsibility to respond to all health related incidents in the school setting (Cagginello, Clark, Compton, Davis, Healy, Hoffmann, & Tuck, 2011). Her professional nurses training and nursing practice to assess, plan, implement, and evaluate individual response to illness closely parallels the steps taken in an emergency (Potter & Perry, 2009). As a nurse, she is prepared to respond to any emergency that occurs while children are at

school. To do that, Ann served on the district's emergency preparedness committee. On several occasions she would bring up the district's emergency preparedness. What I learned was that she had participated in command incident training. Other district nurses were also required to participate along with district principals. She remembered that they participated in triage of a large number of injuries. Red were the dead, yellow the seriously wounded, and green, the walking wounded. Once fire, rescue and police arrived the school personnel helped them to treat and manage the situation.

She recalled one rehearsal for this that she participated in that involved other community responders. They learned some lessons. For example, responder's badges needed to be changed to act as keys to unlock doors. She arrived and could not get into the building.

Emergency situations that she encountered were those most likely to involve a single person that had received injuries and needed emergency care while at school. Her professional nurses training and any recent updates that were required for basic life support certification had prepared her with the skills to respond in ways that supported the physical and emotional needs of all the students she cared for at Wiggle Creek elementary. Her knowledge of the children and her professional training likely support the holistic health care needs in any emergency situation. As the lone medical expert familiar with the children enrolled she would naturally be looked to for the emergency care that was needed, and she was prepared to do that.

### **Monitor Chronic Illness**

Management of Chronic health conditions is also a task that was prescribed by the district that is examined to help construct her professional stance. Giving medications and

the encounters that occur between the nurse and the children receiving it (Bednarski, 2009; Potter & Perry, 2009) was enacted daily at Wiggle Creek Elementary. In the year-long study, prominent in my fieldnotes were activities associated with children managing chronic breathing problems and those taking daily medication to manage behavior related problems. I witnessed the administration of medication regularly and noticed the redundancy of it. As a state licensed health care professional to dispense medication she was required to follow protocol established in the child individual health care plan. She did that regularly to reduce medication errors.

Asthma management was prominent in my fieldnotes too. Ann's activities surrounding these encounters that occurred with breathing reflect her education focus as a professional nurse. She would repeatedly instruct students to come to her office before they participated in physical activity. Then, if they forgot, she would remind them of the symptoms they had encountered and discussed how their inhaler helped them manage symptoms if they received the medication before exercise.

### **School Nurse Perspective**

Reflecting on the list of prescribed activities (health screenings, control communicable diseases, emergency preparedness, teaching health related curriculum and management of chronic health conditions) that her district required of her opens up the opportunity to speculate on how she views the world. We can view how she conducted herself as a mosaic and draw conclusions about her perspective. Behavior that is salient reflects her professional stance to answer the question: Who is Ann? The fact that she acted in multiple consistent ways assumes that she acts as an agent in multiple systems of interaction (Burke and Stets, 2009). Having said that, it is reasonable to speculate that

her professional perspective is one that resonates most closely with an ecological perspective as she views the world as an integrated whole rather than a dissociated collection of parts (Van Sell, 2002). Her perspective incorporates the children's own subjective feeling of being unhealthy or healthy and recognizes the interdependence of all phenomena. As individuals and members of society everyone is ultimately dependent or influenced by each other. (Arvidsson & Fridlund, 2005). Moreover, it is also possible to speculate that her ecological perspective evolved from a holistic paradigm. Van Sell (2002) suggests that most nurses, because they view their clients as an integrated whole, practice nursing from a holistic paradigm. I suspect Ann did that too. On a regular basis, as she made her nursing assessment for why the child had come to her office, she also would inquire about family and/or what the child had been doing prior to coming to her for care.

Her personal perspective resonates most closely with a realist worldview. Especially when it is defined as an attitude of accepting a situation as it is and being prepared to deal with it (Oxford University, 2011). A realist perspective integrates seamlessly with a professional ecological perspective to account for what got enacted.

Interestingly, one late November morning, Ann acknowledged that "Tomorrow is another day." It summarizes her personal philosophy. Her experience, knowledge and stance had taught her that tomorrow would be filled with encounters that would require her to respond from within the framework of nursing practice, and to use personal traits she had honed through time. She would rely on them to meet the health care needs of the children that would come to her.



### **Comment**

The next three chapters utilize my fieldnotes, interviews, and artifacts (electronic and paper copies that Ann contributed) to gain an understanding of what a school nurse does. Chapter five presents the activities of the school nurse related to medication administration – the regularly repeated behaviors that were enacted daily associated with dispensing prescription medication while a child was at school. Chapter six presents the regularly repeated activities of the school nurse enacted as encounters with children that had come to the health office because they wanted her attention and help with a physical need. Chapter seven addresses the school nurse's role in information tracking. It presents the variety of information that the school nurse is required to keep track of, document for the construction of electronic required health records, and to communicate to others.

## **Chapter Five**

### **Daily Medications**

There is still one cup filled with water standing on the counter. Ann notices it, and as she does, in walks Cheryl. She grabs the cup of water, Beth gets up from where she is seated at her desk, unlocks the cupboard where medications are stored, removes the amber bottle labeled with the student's name, and empties the tablet onto the student's tongue. The student drinks from the cup and swallows the tablet, then turns to leave the health office. (5/23/11)

My fieldnote introduces the activities the nurse contributes to the management of chronic health conditions enacted as daily administration of medication at Wiggle Creek Elementary. In this instance, it was the last child arriving for her daily medication at noon. But in general, the above episode introduces a recurring process that was repeated regularly at scheduled times during the school day – every morning as students arrived, then again around lunchtime, and for some students a few hours later in the afternoon. The above episode introduces who is involved, what they do, and where they do it. Simply put, in the event above an elementary student is administered a prescription medication dispensed by the school's health technician in the school's health office as the school nurse looks on. But there is much more involved with administering medication. This is a significant role of Ann's to improve the possibility of children being in their classroom. Here she played a supervisory role by delegating the responsibility of dispensing medication delivery to the health technician. While this incident could be described as mundane, it hints at the complexity of the process of administering prescribed medication to children while they are in attendance at school. Not all children

arrived in the health office ready and willing to comply with taking their medicine - sometimes they resisted.

Examining what occurred at Wiggle Creek Elementary as the school nurse assisted children in management of their chronic health conditions (e.g., medication administration) helps to contribute to a fuller account of what a school nurse does. The account begins with attention to local, state, and federal rules, regulations and policy regarding medication administration (including policy, rules and regulations related to the position of a registered nurse and unlicensed personnel).

### **Policy Regulating Medication Administration**

Ann was a registered nurse that was credentialed by the state and local policy to delegate this responsibility to the health technician to administer medication.<sup>1</sup> Her district's policy states "medication will be administered only in accordance with the Medication Aide Act and Lincoln Public Schools Board Policy 5503" (Health Services, 2010). Both policies require the health technician in the health office to complete the district training prior to serving in the health office and to complete yearly update training and competency testing thereafter to dispense medication under the supervision of the school's nurse.

Employing trained health technicians to dispense medication was necessitated by the fact that the district's nurses were often assigned to more than one elementary school. Ann served as the school nurse in two of the district's elementary schools. She alternated the days that she worked at Wiggle Creek with her other school - two days one week and three days the next. A full time health technician had another benefit. That benefit was

consistency in dispensing medication. An act that likely promoted establishing routines for the children while they were at school to regularly take their prescription medication.

### **Role of Health Technician Training**

A core portion of Beth's yearly update and competency assessment had focused on the standards to ensure safe nursing practice to dispense medications. The notebook that Beth received at this training had been kept in the health office for her use as a reference. While we discussed her yearly update, Beth pulled out a pink sheet from the notebook that listed the "Rights of Dispensing Medication. She iterated that if she ever noticed that any of these were not right (or does not match) she was not to give the medication.<sup>2</sup> Beth described Ann's help with problems in dispensing medications this way, "when Ann is not at Wiggle Creek, she is only a phone call away."

When medications were dispensed, I noticed both Ann's and Beth's adherence to standard practice. I regularly noticed them checking to make sure that the right student had the right medication, at the right time, and in the right dose. And, as the final step, they documented in the electronic health records that the medication had been administered. At Wiggle Creek Elementary, children received medication in compliance with the district's rules and regulation as found on the district's website and in their student handbook. Ann saw to that.

On rare occasions, when both Ann and Beth had been called away from the building, others had also been trained for medication administration. For example, the school's secretary was one such person who had been determined to be competent to provide medication if it could not be delayed until one of them returned. (Health Services, 2010). However, when it was known in advance that neither Ann nor Beth

would be available, a substitute health technician or nurse would be called to fill in assuming their regular duties until one of them returned. In any event, daily medication administration was regularly provided for children that required it.

### **Role of Nurse Qualifications**

Besides following policies to ensure safe medication administration at Wiggle Creek, Ann's qualifications as a practicing nurse in an educational setting also helps to account for the safe and beneficial administration of medication to students while they are at school. Her growing professional nursing experience, which includes past work on a pediatric ward of a large local hospital and ongoing as a school nurse for this district at several schools, contributes to her ability to safely provide children with their prescription medication.

The school nurse is the medical expert in this context. The School District relied on her expert knowledge. The school had the right "to review and decline requests to administer or provide medications which are not consistent with standard pharmacological references, ...prescribed in daily doses which exceed the recommended dosage, or which could be prescribed in a manner which would eliminate the need to administer during school hours" (School Health Services, 2010). Her training and experience equipped her to have knowledge of standard dosages and knowledge of current medical treatment/care plans. Her expertise positioned her to confront parents that requested nonstandard doses and helped to negotiate what she and the school were comfortable with.

### **Role of Training Parents**

Ann's role in interacting with parents to manage chronic illness merits mentioning

because it adds to the account of what a school nurse does. For Ann, dispensing medication at school began with the parent's consent. She was adamant about that, and regularly iterated, "nobody can do anything about it [give medication]... except mom [parent]." Simply put, parents were responsible for supplying the medication in its original pharmacy labeled container or supply the doctor's written prescription (i.e., provide the health office with a copy of the medical authorization) submitted with the medication in its original bottle (Health Services, 2010).

In addition to dispensing medications, her district specifically required that "any child whose health concerns require attention during the school day that parents ask to meet with school officials to develop the child's Individual Healthcare Plan." (Health Services, 2010) As the school's medical expert and provider, she regularly meet with parents to develop health plans (Health Services) in adherence to local, state and/or federal policies.

Her efforts towards what she and what the school expected from parents was always an ongoing process. To inform parents about medication administration, the school had two separate publically available sources that supplied information. Both the school (e.g., *Wiggle Creek Elementary School Calendar & Family Handbook*<sup>3</sup>) and the district's website provided the necessary information and directions for parents to obtain health care needs for their child while in attendance at Wiggle Creek (e.g., complete the form for administration of formulary drugs such as pain relievers or directions to return consent forms to the health office). Ann expected that the district procedures be followed, that is, parents contacted the health office about their child's health concerns and to take the lead to initiate scheduling a meeting with her (school nurse) to address specific health

concerns. Unfortunately, these district directions often were not followed. When parents did not communicate with Ann, she would contact them to schedule meetings to assure that a child's chronic illness was monitored (e.g., develop a student Individual Health Plan (IHP) or parents completed consent forms to supply the medication to be dispensed at school).

In general, Ann suggested that parental consent and the supply of the medication to the school began when a parent enrolled their son/daughter. Joan, the school secretary, had parents complete the health form in the school office. She would then deliver the consent forms and any bottles of prescription medication that were given to her at the time of enrollment to Ann in the Health Office. Then to establish daily administration of the medicine Ann would contact the child, their teacher, and parents.

Prompted by two amber bottles setting on Beth's desk late in March, I asked her to tell me how children developed the same routine as the other children already taking a daily medication. Beth's sense of it was that the children were able to learn quickly, especially older students that had transferred from another school in the district. Students already familiar with the routine of taking 'meds' at another school identified with taking daily medications at Wiggle Creek too - especially when the identity was a salient one (Burke & Stets, 2009). For older children, that had taken the medication for a while, it demonstrated that they had learned to manage their chronic illness.

An additional resource for getting parent consent forms signed was the parent group that met regularly on Wednesday during school hours. Occasionally, if she needed to get forms completed and signed, she would ask the family services coordinator to invite parents to stop by her office while the parent was at school to complete the health

forms. I noticed parents from this particular group regularly stopping in to visit, asking questions and completing forms for Ann. Since the parent was already at school, it was a convenient way to get the required consent and supply of medicine. Her door was always open to them at this time or any time a need arose. Her effort to dialogue with parents perpetuated her effort to maintain caring relations with children and their parents.

Dialoguing with any of the children's parents was her effort to stay connected. Ann's effort to regularly dialogue with parents was a connection that she established that would help to maintain therapeutic medication levels.

Along with meeting parents at opportune times at school she also worked towards improving parent involvement to manage chronic health conditions through phone contact. Her held belief was that "nobody can do anything about [medication and health care] except mom [parent]" was challenging at times to contact them this way.

Sometimes she left messages asking for a return call from parents and then no response was received. She was persistent. Nevertheless, once the medication was delivered to the health office, either she or Beth would begin the process of teaching children to regularly take their daily medication. Contacting (email and/or a phone call) the child's teacher informing them that the child would need to come to the health office at specific times of the day was a necessary first step. Because Ann worked towards minimizing time-out-of-seat for health management, she had a system that involved a phone call with two rings (buzzes) to the child's classroom as a reminder to come to the health office for their daily medication. The child soon developed a routine and arrived for their medicine when expected.



Sometimes authorization began when a child forgot to take their medicine and the teacher, noticing unusual classroom behavior, would come to the health office to inquiry about whether the child missed their medication. For Ann, when a teacher was concerned about student behavior and inquired about possible missed medication, it usually initiated a phone call home to offer the schools help. Ann informed me that her conversations with parents would be to encourage them to view giving medication at school as beneficial for their child. For example she said, “I tell them that a lot of children take daily meds,” or “we know that you are busy and this way you will know that the medicine is given.”

### **Daily Medication: Capsules and Tablets**

On most days at Wiggle Creek Elementary, Ann delegated administration of prescription medications (the tablets and capsules) to the health technician, Beth. Usually there were around ten students arriving in the health office to receive their ‘daily meds’ (Ann’s term for the prescription medications dispensed daily) at a given time. The number might vary because children that were expected to take daily medication were absent from school or there might be newly enrolled students.

To administer the morning medications, Beth would arrive early before the children were allowed in the building to prepare the medication for dispensing. Then, when the children were allowed in the building, they would come to the health office first for their medication, and then walk to the cafeteria to eat their school breakfast. The health office was located just inside the front entrance; the cafeteria was much further away. Once the medication was dispensed, the process ended with electronic health record documentation of the event for each child receiving medication at that time.

Dispensing the ‘morning meds’ prior to breakfast was an essential strategy to help children comply with the act of taking a daily medication. Breakfast at Wiggle Creek was free for all students; thus it could be used as an added incentive to prompt children receiving daily medications to arrive early and not miss time from their classroom for their medications.

Then the process started all over again around noon. The routine was the same but the children might be different (i.e. children arriving early may only receive medicine one time). Few children received daily medication after lunch. If they did, it was because they were attending an after school club where the health office could follow-up if they had not come into the health office within the hour that the medication could be given.

On the days that Beth was not at the school, Ann administered daily medications. Both Ann and Beth administered medications similarly. The children receiving daily ‘meds’ were taught the routine of regularly arriving for their medicine, and uneventfully accomplishing the task in a minimum amount of time.

In particular, the steps that Ann and Beth regularly followed were as follows: 10 to 15 minutes before the first child typically arrived all vials were removed from the baskets in the locked cupboard; prescription doses (capsules or tablets) were placed in the vial caps and replaced upside down on the vial; the vials were placed in alphabetical order on the shelf just in front of the alphabetized baskets of medications in the locked cupboard. Then when the children arrived to receive their meds, they were acknowledged by name (evidence that Ann and Beth knew them), the name on the vial was matched with the child, and they were asked why they had come to the health office.

Vigilance in standing beside them to notice that the medicine had been swallowed (i.e., they had consumed the medication) was also a standard step in the procedure.

Children always took their medicine. Sometimes it might be their body language that suggested a defiant disposition, but they too always took all of the medicine that had been prescribed for their particular therapeutic dose. When Ann noticed any reluctance to comply, she would praise them once the medicine was taken; describing them as being GREAT for taking all the pills (some had up to three). Ann was consistent with positive statements about doing a good job in taking the medication.

Both Ann and Beth were flexible with letting the children take charge of some of their behavior related to what they did to take their ‘daily meds’ as long as it was appropriate for their particular medication. For Billy it was a decision about what to do with the water she gave him to drink with his tablet or capsule. When he arrived in the health office for his noon medication, Beth recognized him and called him by name, and dispensed his medicine into his hand. He put it into his mouth, swallowed, and then rinsed his mouth three times with the water. Beth just watched with a puzzled look on her face. She had noticed that he swallowed the medication. She would allow him to make the decision about what to do with the water. When he turned to walk out of the room, Ann looked up from her computer work, and said, “Bye.”

Billy had a choice of things he could do to after he swallowed his medicine. Most of the time, children would drink the water to ease the swallowing process. But Ann consistently made it known to the children that had come for “daily meds”, even when she was not the one administering the medication, that she knew they had come to do what she had expected of them. They were learning to be responsible. Sometimes her

words were complimentary of the child such as “I like your hair,” a simple “bye,” or just a smile to let them know she cared about them, and was pleased about what they had done. The children acknowledged her too, and usually responded likewise.

Interestingly, in December Ann commented, “I bet you could do everything that there is to do here.” Her comment was reflective of her assessment of seeing what she did as redundant and repetitive. I agreed; dispensing capsules and tablets was a clearly established routine that even I had become familiar with. Nursing practice values regular routines to minimize the possibility of errors in medication administration (Potter & Perry, 2005). Both her professional training and her experience with routines had taught her the benefits of doing it this way.

As a nurse in an educational context she regularly assumed the role of teacher too. Her teacher role required that she regularly evaluate learning related to children’s management of their chronic health conditions. In this role, opportunities to evaluate learning might be about student skills such as prompt arrival, willingness to comply with taking the medicine, and transitioning back to their classroom. Successful daily maintenance of a therapeutic effect relied on the child’s ability to consistently consume the tablets; it demonstrated that teaching and learning had occurred.

### **Modifications to Administering Medications**

Her specialized pediatric nursing skills were useful in situations with children who required daily medication but had diminished mental capacity related to cognition and/or exhibited behavior below the child’s corresponding chronological age. If talking to the children about benefits of the medicine was not enough, and they noticed that their medicine made them feel terrible or it left a bad taste in their mouth, she relied on

creative ways to make the medicine palatable. She would first check with safe administration guidelines in her medication manuals or reference material to ensure that the tablet could be safely crushed. For example, she might crush tablets and mix the powder with very small amounts of food or liquid. For some of the children this was a regular occurrence. For example, she frequently used applesauce to mix with crushed tablets. Furthermore, her personal knowledge of what a child liked and her experience with children from the past also helped her to know what children were likely to agree to eat. While there is caution in using a child's favorite food to mix with medicine because of the likelihood of it making the favorite food taste bad, Ann tried that too (Potter & Perry, 2005). For example, for another child she mixed a crushed tablet with chocolate pudding as the means to administer the medication. While the pudding was helpful, in this instance, Ann's caring actions were also necessary for compliance. In some instances it would take Beth and Ann working as team to administer the medicine. When Sonya arrived escorted by Mr. Madison, the pudding and crushed tablet mixture were ready for administering. Ann spoke first asking, "How are you?" Immediately she spoke about how 'yummy' the chocolate pudding was, and that she loved pudding too. Once Sonya was situated on Ann's lap, Beth administered one partial spoonful. Ann instructed saying "Yummy, yummy, swallow, swallow, big bites." Sonya resisted a little, but she did swallow successfully the pudding and crushed medicine mixture.

One cannot help but wonder how badly the medicine must have tasted mixed with the pudding. Ann's insistence and persistence, proximity, and the relationship she had built with the child all encouraged compliance. Once the thick mixture was swallowed Sonya was allowed to get a paper cup for her drink. With Ann's help, Sonya was able to

fill it with water to wash the last traces of medicine down. It was interesting to watch Ann and Sonya interact at the sink. After ‘eating’ her medicine successfully, Sonya became so excited from praise and completing the task that Ann had expected of her, that Ann had to caution her to stop jumping up and down, “You’re spilling your water,” she warned. After the spilled water was wiped up, Mr. Madison and Sonya were on their way out of the health office.

Ann had other creative combinations that were all in compliance with safe and effective guidelines. For example, for one of the children, she had found that miniature peanut butter cup candy was the only palatable form. When Sandy arrived the candy with the crushed tablet was waiting in the locked cupboard. Opening the cupboard Ann said, “Wow you get a big one today.” Sandy seemed genuinely pleased, but did not start eating it; instead she placed her bag of toys on the same desk where her medicine was waiting. Then after she seated herself, she began eating the candy. Ann stood close to her and so did her teacher, Mr. Madison. Ann reminded her to “eat all of the candy.” She did. Once it was completely gone, she got her drink of water.

A few days later, Sandy had gagged a little after she tasted the candy. While she needed Ann’s watchful eye and more coaxing, the process continued uneventfully, she got her drink, and left the health office to return to her classroom. Still another time Sandy sat down, but instead of eating the medicine she began playing with it. This time Mr. Madison used firm words, “EAT IT!” She did, but Ann was quick with words to lighten the situation: “You must have been hungry.” Once again, I am reminded of Ann talking to children about the benefits of taking their medicine. And how she was skilled

at caring for children. Another time she commented about how Sandy was doing so much better since she was getting her medicine. Sandy smiled when she heard that. It had been a struggle to get her to take her medicine until Ann discovered she loved peanut butter. Since then, putting the crushed medicine into the candy filling and re-assembling it, even replacing the original candy wrapper had improved compliance. The repetition of always setting at the desk with the candy placed there on a tissue and the habituation of sequential activities all served as teaching tools to help this child take daily medication. The child's positive response to taking all of the medication, even when it had made her gag, describes uneventful compliance that provides the constant therapeutic dose and increases the student's ability to participate in learning in the classroom.

### **Building Relationships with Children**

Ann's soft-spoken consistent positive response to children is a teaching tool that was prominent in the study. It was effective in de-escalating frustration and anger. It was noticeably different from the confrontational style of some teachers. Ann preferred an unemotional approach at first in tense situations, and 'wait' time for children to sense the calm ambience that they were surrounded with; it de-escalated the situation. Her focus was always on allowing the child to explain their need. Her face-to-face encounter 'caring for' a physical need appeared to help children gain control of their behavior.

**Just visiting.** What is more, the children that must come on a regular basis for daily medication sometimes stopped in just to visit. Once they were in the health office a brief friendly conversation ensued. Ann kept the conversation short and reminded them of where they should be at the time. For example, one day in late May, Kelly entered the health office carrying a book. It was not time for medication. She simply walked over to

Ann to get a big hug. After hugging, Kelly admitted quietly that her finger hurt. Ann cared for her finger and put an adhesive bandage on it. She was sent on her way to the library. Ann summarized the encounter with Kelly this way: “I first thought she had low maturity. We rarely see her have an episode (bad behavior), but we don’t challenge her.” The relationship that the two shared, built from interacting on a daily basis demonstrated meeting the care Sonya desired physically, socially and emotionally (Lightfoot & Bines, 1999). For Kelly, the health office had become a safe place to go. And, I think it demonstrates how Noddings (2002) describes a caring person as “one who fairly regularly establishes caring relations and, when appropriate, maintains them over time” (p. 19).

**Rewards.** After settling into my little blue chair, I did my usual scan of the room. Noticeable that day was a big yellow sign on the table – “Its Friday!” Beside it was a big bag of popped corn along with paper cups filled with popcorn. The festive sign added to the value of the reward. Ann was ready for celebrating with the children what they had accomplished. Every child that took medicine on a regular basis would be getting their treat if they had been faithful in coming in every day, know matter how many times they were required to do that - one miss; no popcorn. Her belief was that “the kids look forward to it, and are genuinely pleased” that they have accomplished not missing one dose of their medicine while at school. For Ann, it had meant that they were learning to be responsible and were also benefitting from maintaining the therapeutic dose that had been prescribed to manage a chronic health problem.

**Continued vigilance.** Teaching children to regularly take a daily medicine did not always follow the expected routine. Sometimes they would not receive her popcorn



reward on Friday. A variety of circumstances prevented arrival in the health office at regularly scheduled times. On occasion the circumstance may have been problems with classroom events. However, no matter what the circumstance, it was Ann's responsibility to make sure a child received required medications, and to meet this responsibility she would investigate, and cooperate with the classroom teacher in the least disruptive way.

Ann's continued vigilance over daily medication administration ensured that all children scheduled to take medication did take their medication. Her actions to do that showcase her role of medical caregiver enacted as she dispenses a prescription medication following nursing practice protocol – right child, dose, time and the like. And her role of teacher is enacted as an evaluator of learning. Children demonstrated that they had learned when they acted responsibly and independently arriving alone to take their medicine. Ann regularly taught those who came for 'daily meds' to move quickly through the process of taking medication. When children delayed, she would instruct saying, "better hurry, hurry." When she noticed a negative attitude, she would confront the child saying, "Are you mad at me?" Engaging in conversation unrelated to why the child was in the health office was a strategy Ann regularly used to build relationships with children. Her question implies a relationship and suggests that she cared about more than taking medicine. She only challenged them to do take their medicine, thus most of the encounters were uncomplicated and usually uneventful, and they missed only a minimal amount of time from their classroom.

Typically, Ann would confirm with Beth, which students had not yet come in, and one of them would volunteer to follow-up on the student's noncompliance. Mid-April, I

Ann noticed that Buddy and John had not taken their medicine. Looking at the clock she announces, “I have to check to see if they are here.” With that said, she left the room.

“Yep, John is gone, and he will not be back” she said when she arrived back in the health office. After awhile, Ann took the medicine to where she knew Buddy was.

The one-hour limit for administering the medicine was ending and Ann needed to do what she could to meet that time limit. In this instance, she received a phone call that prompted her to take the medicine to the child rather than the child come to the health office; she was back in less than five minutes. For another child with different circumstances, she might request the student come to the office. It gave her the opportunity to visit face-to-face with them about the benefits of coming to the health office when they were scheduled, and remind them of her popcorn reward.

In all cases her decision to make sure a child received their daily medication was based on her evaluation of what was best for the child. She was aware of special circumstances and worked closely with teachers to keep children in the classroom. This strategy minimized disruption in classroom instruction yet enabled self-management skill learning. Towards the end of the school year she adjusted what she did because she was aware of changing classroom activities, and that these changes made it difficult for students to comply. She commented, “Students have only two school days left for the year; going into the classroom will not be much of a disruption.” The assumption being that classroom schedules and changing routines raised the possibility those disruptions were expected. Her choice to administer medication in the classroom (on rare occasions) would probably go unnoticed, and would benefit the child maintaining the therapeutic dose of prescribed medication.

Changes in classroom routines were not the only circumstances that complicated daily medication administration. On occasion, a child arrived for their daily medication and there would be none to take. When such an event occurred Ann would pull their amber vial out of the basket and show the student that it was empty. Most of the time her actions were enough to prompt the student to remember where the medicine was. After seeing the empty container, Lee realized his pills were in his backpack, so he left to get them. He arrived back in the health office escorted by Joan and no medicine. The story, according to Joan, was that he wanted her to give him his noon ‘meds.’ Joan said, “I told him Miss Ann does that” and escorted him to the health office. Ann’s response to the child was, “Get your medicine out of your back pack.” He left again. When he returned he had his medicine. Lee put the medication on Ann’s desk, took one and grabbed a cup filled with water to help wash it down. In this instance what happened next added to his confusion, but also allowed for the safe administration of medications. A substitute health technician stopped Lee from taking his medication. She had not completely understood what was going on. Her actions reflected her training to ensure safe administration of medications and adherence to the “Standard Rights” for dispensing medicine. She asked for his name, checked to make sure it was the right medication and the other rights previously mentioned. While she did that, Ann noticed the confusion; she immediately intervened for the student and he was given his green capsule. He put it in his mouth, swallowed some water and left the room.

Ann knew Lee well; he had been regularly arriving for his daily medication for several years. The substitute technician’s actions showcase following the training she received for administering medication; Ann’s actions also demonstrate the safe

administration of medication. The right child received the right medication, at the right time in the right dosage.

Vigilance, on Ann's part, was expected to keep a steady supply of capsules or tablets on hand to daily dispense. To prevent an incident such as the one with Lee, Ann regularly called parents and also told the child receiving the medicine when they had a minimum of two doses left. The computer software used to track and document health records in the health office was designed to alert her to the number of doses remaining. Her faithful documentation of giving the doses enabled the computer to automatically subtract the number of doses available. This information assisted Ann with communicating with parents about maintaining a constant supply of medicine.

Her "two doses left" policy was not soon enough for some to keep up with a continuous supply. Ann often modified this policy, based on past compliance with keeping a supply of 'meds' at school; it ensured that medications would not be interrupted. In some cases she would call parents when they still had a week of doses left. Ann described it as "in some unusual cases it just did not matter if it were two days or a one weeks notice." Often when notified that "you need more pills" parents would still not get the pills there for uninterrupted dispensing. She knew the students well. As a result, she used reminders that she thought would work on an individual basis. She summarized it as, "Some are not forth coming about getting meds."

Her vigilance was also expected regarding the safe keeping of medicine at school. The prescription medicines and formulary medicines were safely locked in the cupboard in the health office. On a regular basis, Ann was responsible for hand counting the

capsules or tablets to reconcile with the computer count and the number of tablets or capsules in the amber vials.

When parents chose to administer daily medication at home, Ann was expected to care for the child and the problems that ensued because of missing a dose. Skipping a dose at home could create quite a flurry of activity at school. When this occurred, activities involved encounters with adults (e.g., the child's teacher, administrators, office personal and the health office staff) that were not routine.

Jonathon entered the health office escorted by Mr. Madison. He explained that Joan had suggested that Ann listen to Jonathon's chest. To do that Ann repeatedly called him by name, and then finally she whistled to get his attention. Jonathon looked at Ann and said, "I can't pay attention." Recognizing him as one that she had given 'daily meds' to last year, but not this year, she got out her stethoscope from the top drawer of her desk and listened to his chest. She listened to his back too. When she finished she said, "Go wait by Miss Suzy. You can focus for that long." He agreed, but then asked, "Can I lie down on one of the cots? Can't I get some water?" Ann filled a small paper cup with water and gave it to him. The adult walked with him out of the health office room.

Ann's caring response to a child that acts in unpredictable ways is of interest because she is caring for him, even though he does not respond to her. After the student left, Ann explained, "he is an example of a child that his parents forgot to give him his 'meds' this morning. He tries so hard to be good, but just can't without his medication." In her phone call to his parent, she talked about the benefits of having the health office dispense his medication. She iterated that she understood that their mornings were hectic, and that

if the school gave him his medicine it would be one less thing for them, as busy parents, to do. She stressed that if the health office were to give his ‘meds’ they would know they were given, and shared that at the time they had approximately fifteen students taking daily medications. Therefore, he would not be singled out. She visited about other positive benefits besides the continued maintenance of the therapeutic level of the medication, such as the reward she had for him on Friday for students who had not missed one dose during the week.

Ann felt strongly that giving medication for daily therapeutic effect was an important role that she could play to help children stay in their classroom to learn. As the school’s medical expert she had presented the benefits to the parent of a specific child. Whether or not the parent would enlist the health office to dispense the medicine was not within her control. Her goal had been to communicate with the parent, as she did with all parents, in presenting the possible benefits of using the resources of the health office. That was all she could do because it was ultimately the parents’ decision where and how to manage their child’s chronic health problem.

### **Daily Care: Asthma Management**

Not all medications that were regularly dispensed were capsules or tablets; some were liquid and were administered as a mist (e.g., inhalers for asthma management). The children receiving daily asthma medication are best described as arriving to receive treatment for their asthma before symptoms are present. All children receiving asthma medication were also taught skills to manage asthma (i.e., to avoid asthma triggers and proper self-administration). Ann’s professional training and years of experience working

with children had taught her that regular contact with asthmatic students increased their chances of learning skills to better manage asthma triggers and symptoms.

She believed that elementary age children had difficulty understanding why they used an inhaler. Interestingly, she recalled a time when a child was caught sharing his inhaler with another child that had a cough. The child believed his inhaler had been for a cough and that he was helping his friend. Furthermore, Ann strongly believed that allowing elementary age children to keep their asthma inhalers on their person during the school day invited misuse. At Wiggle Creek she strongly recommended adherence to the policy that all medication (including inhalers) should be kept in the health office.

Occasionally, parents would insist that their child keep their inhaler with them or be allowed to keep it in their school bag. When this happened she as the nurse, along with the child, the child's doctor and the parent must be willing to sign a waiver for school policy – all inhalers must be kept in the health office. She admitted that she was likely to not sign the waiver. Ann reiterated that, “often the child has no idea when or why they use it. I don't believe in allowing elementary age children to carry an inhaler at school.” She did allow the children to take their stored inhaler home, but expected them to return it to her the next day.

Because children requiring asthma medication to treat symptoms would be the same ones over and over, it appears that teaching elementary age children to manage asthma is complicated. This chronic condition varies in severity and varies with the child's ability to understand that their actions are directly related to their breathing and management of it. Ann daily encountered children with asthma and described some success with teaching skills that improved their self-management of it. For example, I

noticed from my fieldnotes that children with severe cases of asthma (difficulty controlling asthmatic symptoms) visited the health office complaining of difficulty breathing on most of the days that I was there to observe. Ann's activities to treat asthma related symptoms followed a pattern. When any child entered the office with obvious breathing problems she (or Beth) would immediately get out the child's prescription breathing treatment medications from the locked cupboard. When Beth gave the inhaler to the child, Ann would add her comfort to calm them. For example, she might put her arm around their shoulders and walk together with them to the table where she would seat him/her to self-administer the asthma prescription medication. I noticed that while she resumed her other duties she always kept a watchful eye on the child as they independently treated themselves adding comforting words such as "good job" or "I bet you are feeling better."

At other times, to care for children with severe asthma, Ann would go to them. If the episode occurred at outdoor recess she would go to them there. In the second week of May, when I arrived at Wiggle Creek, I saw Ann outside, seated at a table with a child beside her. Ann described the student as having trouble breathing at recess, and she had gone out to help. She had quickly grabbed the child's inhaler from the locked cupboard to take it with her. Later she told me "I gave her a lecture about how she must come into the health office before she plays at recess." Ann's use of the word "lecture" was her way to remind Jill of the routine she had been teaching her and that she had not practiced it properly. This teachable moment not only allowed her to help the child learn about the choices she had made, but also learn how to successfully manage her asthma and participate in the fun that she looked forward to at recess. After documenting the incident



into her electronic health records, she called the child's parent to inform them of what had happened and what she had done in accordance with the child's Individual Health Plan (e.g., number of inhaler doses and the times these were given). What she had taught in this acute situation, Ann regularly taught with other diagnosed asthmatics about their asthma symptoms during a teachable moment tied to actual symptoms. For example, she would ask them about their class schedule, and what time they had recess or their physical education class. Her goal was to help them prevent or reduce the severity of asthma flares. On an individual basis, Ann would create steps and strategies for the child to take, and helped them to regularly practice them to prevent flares that occurred when they engaged in rigorous activity. Her efforts as a medical care giver and as a teacher demonstrate what a nurse does in these dual roles in a specific context to keep students stay in the classroom. Jill's recess time had been extended to care for her physical needs, but teaching and learning had taken place in a meaningful context towards her improving her ability to manage her chronic health condition.

Most children with asthma arrived in the health office as part of their normal routine to manage their asthma while at school. They regularly arrived before recess or physical education class, to prevent asthma flares. Ann had taught them how to do that. I noticed that while children were administering their asthma treatment Ann talked to them. Their informal conversation while she is observed self-managing is note worthy. Ann regularly interacted with children at a personal level when they came to her for medical care. This important interaction served to help her communicate with the children and to build a caring relationship too. In this instance, the questions and informal talk were carefully interspersed between puffs; it did not interfere with the child

dosing herself properly. I noticed that Ann remained seated at her desk to give careful attention from there to what Shari was doing, but not commenting on the technique. What I observed was conversation that blended together as normal social behavior. The assumption is that for this child, at least while at school, she had learned asthma management skills to help keep her in the classroom. She had participated in a routine to self manage her chronic health condition under the supervision of a skilled healthcare professional.

On the days Len and Jane had Physical Education, they arrived in the health office just before class for their inhaler medication. They too were asked similar questions to any of the children mentioned above that would be receive medication. Beth was the one to get each of their inhalers out of the locked cupboard. Following procedure for district policy to administer medication, Beth checked names and gave the identified student their prescription inhaler. They too knew what to do. As they shook the medicine, Ann commented, in a light-hearted manner, that they looked like they were doing the “salsa” or maybe the “cha cha”. Len had counted, and on the count of three each took a puff. Then, after the required wait time, he counted again for the two of them, and they each took another puff. The students placed their inhalers on Beth’s desk, and hurried out the door for their physical education class.

While many students did remember to come into the health office for their inhaler prior to exercise or before events that caused their asthma flares, others were like Jill in that they did not always remember to follow their asthma management plan. It did not surprise Ann; her experience had taught her to expect that. For example, children would come into the health office and follow the management routine, such as the one discussed

above and just days later would arrive with breathing symptoms needing their inhaler. Horner (2004) suggests that because school nurses have extensive contact with children affected by asthma they are positioned to implement asthma management education. For example, I observed one child who seemed to have the routine established but had not made the connection of why the medication was needed. In this instance the student walked in gasping for air. Ann noticed and went to the cupboard to grab her inhaler. While she did that she began a dialogue by asking about what she had been doing, and where she had come from. It was her attempt to understand what had possibly caused the struggle with breathing. Then Jill explained that she was on her way to physical education class and had to run to the health office for her inhaler treatment. Ann gave her the inhaler and Jill self-administered as she had been taught to do. While she did that, Ann said, "Your hair sure smells good" generating a conversation about the shampoo she had used. Ann sat at her desk and continued to work at her computer. Then, suddenly, an abrupt whistle sound could be heard. Ann instantly looked at the child and said, "You saw my head pop up?" A piece of the inhaler had fallen on the floor but the student had left it there. To get the child to pick it up she said, "Look at all of the germs getting on top of it." To that the child picked it up. Ann had kept her interaction with the student positive. Absent from this face-to-face encounter is her scolding the child for her negative behavior of running in the hallway, but rather she encouraged the regular use of her inhaler. Further, when she dropped a part of the inhaler on the floor she had used humor to get her to pick it up. What is noteworthy is that Ann is familiar with the children's behavior; she understands the complexity of it and she adjusts teaching strategies to get the behavior that she expects. Finally, Ann's effort to establish regular

routines, for this child during the school day had not been interrupted, and she was quickly sent on to participate in her physical education class.

At other times the asthma symptoms are just too difficult to resolve. For example, I noticed a child arrive in the health office announcing that she was having trouble breathing. Because she had just been in to use her inhaler she was told, “I will have to call your mommy to take you home.” Ann gave her some warm water to drink while she waited for mommy. Grandma arrived instead of mommy, and because Ann had knowledge that Grandma was an emergency contact listed by the parent, the child was allowed to leave with her. But, before they left, Ann described (time and doses) what she had done and the observed effect (still struggling with breathing) to Grandma. To further communicate with the child’s parent, Grandma was also given written documentation describing what she had done. It was particularly of interest to notice how Ann and Beth worked together to help this little girl get sent home. And, what each had done to care for her. Ann could be described as the one Grandma looked to as the expert for medical advice, when she arrived she spoke to Ann to get the information she needed about her granddaughter. Ann’s leadership qualities (e.g., speaks first, always observing as Beth cares for the children) and her nursing actions led to a temporary resolution for this child. She was sent home for the parent to make health care decisions. After the child left, Ann completed her documentation of the encounter, including the outcome.

Ann’s activities with children struggling to manage asthma focused on her goal of them acquiring health skills to control or manage their chronic condition. She often quizzed them: How long do you wait in between puffs? What time was it when you took the first puff? This assessment helped her to determine if learning had taken place. She

had given them the opportunity to practice in real life what they had learned about using their prescription medication, avoiding identified triggers and adopting this knowledge as part of their normal routine while they were at school. And, as asthma skills were acquired students would benefit in and out of school for a lifetime.

### **Daily Management: Diabetes**

Diabetes is another chronic condition that a school nurse is called upon to spend time managing (Diabetes Public Health Resource, 2011). At the time of this study she had not had any diagnosed diabetics at Wiggle Creek. From past experience and one student with diabetes at her other school she recalled what was expected of her as the school's nurse. For her, monitoring diabetes was heavily influenced by school policy and state regulation of her nursing license. But she did have some flexibility within the individual healthcare plan (IHP). In caring for a student with diabetes, along with implementing the IHP as written, Ann recalled trying to make it interesting for the child. For example, she remembered that she might ask middle school age students with diabetes to guess what their blood sugar was and then see how close they were. Such teaching strategies helped students to connect how they felt physically to what their blood sugar levels actually were. Her responsibility of documenting blood sugar readings, the amount of insulin given, and when the student had eaten in the electronic health records were crucial to managing blood sugar levels. Summarizing, Ann said, "Diabetics can't stand in the food line for 10 minutes, they can't do that." This comment brings to the fore her concerns for a child with diabetes at her other school. Ann had spent an extended amount of time examining this particular child's health records to make sure she was getting Ann's best care while she was at school. Even though the child was not

at Wiggle Creek, Ann would spend time planning for the child's care there. In a fieldnote I wrote the following:

Sometimes her responsibilities at her other school coincided with her role at Wiggle Creek. For example, on the day when she was scheduled to meet with a diabetic student's parent at her other school she found herself finalizing her plans for the meeting in the midst of caring for children at Wiggle Creek. She always stopped her planning work at her desk when a child entered the health office. She would greet each of them with a smile, and then ask what she could do for them. In every instance she spent time attending to why they had come to her, and sent them back to their classroom after her careful assessment of why they had come to her. Once the child was out of the room she returned to planning. (5/2/11)

Later, she voiced that at the meeting it was her responsibility to report the documented blood sugar levels, the critical piece of evidence to support that the student's management of diabetes had not been going well. Ann worried about parental response to the student's status. She acknowledged that it had been difficult for her to instruct the child on management. She also worried that what she taught at school did not match what the child had been taught at home. Ann was frustrated and was working hard to get a plan in place that supported her professional knowledge of the case. She anticipated that this upcoming meeting would be a difficult challenge, and wanted to be well informed about the particulars that were documented by the child's health records.

At the fore of Ann's thinking was: What else could she do? Related to nursing practice, today was so much different from what she did as a pediatric nurse in a large local hospital in the past. For example, she explained that for children with diabetes, she

had been able to teach her young patients to recognize how it felt when their blood sugar was too high or too low, and to associate that with their carbohydrate intake and energy output. She acknowledged that with today's limited hospital stay it would be tricky to teach skills that were needed to manage a chronic condition such as this one; it just didn't unfold that way anymore. I sensed she wanted to do it the old way.

While we talked informally about diabetes and her expected care of it, children continued to come into the health office. Once the children were gone she returned to her desk to stare at her computer screen. She leaned back in her chair, her back straight and her legs wrapped around the rolling chair's feet. She had concerns about getting approval for what was best medically in this instance. And, reiterated that her ability to promote the benefits of teaching at home with what she was teaching at school would be difficult. For her, what was best for the child was a matter of consistency between school and home. The two had to be synchronized with what the doctor had prescribed. Ann talked at length about what was needed to help this particular student, and acknowledged that she was limited in what she could do.

She described the difficulty of providing constant support. At Wiggle Creek she could walk the cafeteria line with a diabetic student, but at her other school this was not possible because of health office staffing. She hoped to better educate the cafeteria personal to this student's specific needs as a means to manage her diabetes. She had tried this in the past, but it soon became complicated by specific personal not always being available in the cafeteria. Ann acknowledged that possible solutions were further complicated by FERPA and HIPAA and her compliance with what was covered by each of these laws. She admitted that in cases such as this she would think of the child while

she was at home. She concluded with these words: “It scares me! Poor girl, all she can think about is food, food, food.”

### **Daily Management: Medically Fragile Child Care**

Ann also regularly cared for students with disabilities and for those who depended on medical devices such as tracheostomy and gastrostomy tubes on the days that she was at Wiggle Creek. The daily care that a medically fragile child required sometimes created what Ann described as “mixed up days.” In the morning she might be at her other school for a tube feeding and then return to Wiggle Creek where she regularly provided general and specialty nursing care. Because the district is responsible for having available someone to care for students’ health care needs daily, a substitute registered nurse might be asked to come in to care for students that required a registered nurse as a means for providing medical care at two sites at the same time.

In the year that I spent doing fieldwork for the study, I had the opportunity to observe Ann’s regular encounters with one medically fragile child. This vignette from the study data described the encounter and showcased the quality caring that Ann provided.

Ann announced Joey, “Here he is.” She got up from her chair at her desk and washed her hands. He had come for a scheduled medical procedure that only Ann could do. In preparation for the procedure, Ann removed the supplies from the locked cupboard, and prepared them for use. The staff member, Margaret, who accompanied Joey, described the activities that Joey had already done that morning. “Today he picked a song, picked a friend and planted grass.” Ann comments, “You sure are bubbly today.” All the while the procedure progressed Ann talked directly to Joey, “You’re a spring boy,



all dressed so colorful. Do you feel better?” The procedure took approximately 14 minutes. “All done.” Ann stood up, and said to Joey, “Bye, bye, sweetie.” Margaret and Joey left the health office.

The medically fragile child’s attendance was dependent on Ann’s capacity to provide the skilled nursing care the child required while at school. The nursing skills she used to hydrate him were what allowed him to stay in his classroom. Caring for medically fragile children such as Joey reflects Ann’s experience as a pediatric nurse in a large local hospital, and her natural ability to nurture children. Without such care Joey would not have been able to attend school. Simply put, without skilled nursing care he would not survive a school day. His regularly scheduled skilled care would continue for a year (when the IHP would be reviewed) or until special conditions arose for it to change. For his skilled care to change would require written doctor’s orders. When this did occur, most likely the new orders arrived at Wiggle Creek as a faxed document from the doctor’s office. Prior to the receipt of the written order, not even a parent’s request would change what she did. She explained it that way to parents too. While parents were instructed to inform the school with changes in medications, it was written doctor’s orders that brought about the change that Ann would implement.

Other special conditions that were part of the daily monitoring that Ann participated in were the physical environment at school, (e.g., room temperature). In the springtime the transition from the cool temperatures to what were now more like hot summer days occasionally created warmer than usual indoor room temperatures. And knowing that the air-conditioning would not be turned on until the middle of the month, and that the classroom temperature could be getting too warm, she found it necessary to

check on one other medically fragile child that did not tolerate high humidity very well. When she returned from checking on her she reported, “She is fine; she is playing and having a great time.”

As we talked about other special circumstances that she attended to on a daily basis, I learned that she worked closely with parents when their child had a chronic illness but did not require her to administer any special health care. During our informal talk about such cases she expressed surprise that they had not seen a particular student that was currently managing a prolonged illness. Her role was to document the times he arrived in the office with a specific complaint. According to Ann, in cases such as the one above, the child’s teacher was first in-line to have information from the parent about the child. However, if the child was frequently being sent to the health office, then she would assess what she believed was happening. When it was necessary, she would call the parent to give them the information and any observations she had made of behavior in the health office. She found that these calls could be very helpful, especially if she noticed something that the parent had not, and it warranted a trip to the physician. For Ann, contacting parents “it is a two-way street – getting and giving.” She shared what she found while the child was at school, and parents shared what they found while the child was at home.

In addition, in cases such as the one mentioned above and others, her specifically gathered documented findings might also be usefully at Student Assistance Team (SAT) meetings. Her role of health expert and the fact that she had documentation of health concerns including specific things, as number of times the child had been in the office,

the assessment, and attempts to contact parents, helped to explain behavior and was useful in planning the Individual Education Plan (IEP).

### **Transitions: Collaborating**

Along with what regularly occurred, planning for students with healthcare needs was also a fundamental part of what was necessary to implement dispensing of medications for children when they transitioned to a different school. I noticed that early in the spring semester that Ann spent time attending what she called “transition meetings.” For continued care, when children were scheduled to attend a different school in the district, the care providers met to make plans for the child in an anticipated new setting. Her role at these meetings was that of medical care expert for meeting the child’s health care needs while attending Wiggle Creek. For her the process might begin with sending or receiving information through an email message.

One day in Mid-April, while she was at her computer checking her email, she said, “This one, I’ll forward to my boss.” Her concern was that she wanted to make sure the district’s health services supervisor had the information early on too, so planning would take place, and that a healthcare plan would be established before school started in the fall. As we talked about caring for medically fragile children she shared with me that the adults caring for a child would share health information related to the child’s health condition. Then a “transitions” meeting was scheduled to plan for the child’s medical care at their new school and new care providers. The district provided a variety of health care services for any child to attend at the expense of the district. However, she knew that sometimes parents had their own nurse or therapist for the child. But if they did not, the district provided the services. The transition meetings allowed all providers to

discuss the child's anticipated needs, and afforded the opportunity to meet the parents and to meet the child that they would be caring for.

Ann guessed because her other school was in a new building, and was on one floor, that they probably had more students with special health needs than she did at Wiggle Creek. In her opinion, more specific health needs usually meant more transition meetings in the spring. She would spend more time in the fall making sure that children had transitioned successfully into their new environments. For example, early in the fall semester when I arrived for an observation, Ann had not been at her usual place - working at the computer on her desk. Later, when she did arrive, she explained that the adults (mom, teacher and admittedly herself too) were nervous about Andy's behavior, and his keeping a necessary medical device in place to function for him. She had wanted to see for herself how he was adjusting. She told me, "I noticed that he had initially separated himself from the other children in my presence, but soon warmed up nicely. I left because he was interacting appropriately for a three year-old." In this instance, Ann's nursing skills had not been called upon. She had made herself available to intervene in the new environment to provide what was necessary for the child to function in the classroom. While the child had not needed a daily medication, she had provided the necessary nursing support for his daily care.

### **Summary**

When the school nurse provides for direct supervision of daily medication, the children participating in her supervision benefit in two ways: 1) maintenance of therapeutic levels and 2) establishment of habits to take medication daily.

Ann's role in dispensing daily medications was mostly that of supervisor in that she had

delegated this role to Beth. A measure necessitated by the fact that Ann was not full time at Wiggle Creek Elementary; she shared her full time status with one other school. In compliance with district policy, Beth regularly completed district required update training and competency testing to administer daily medication. Ann was meticulous about following federal, state, and district policy that were required of her in providing health care to students with chronic conditions while in school.

Teamwork is the best way to describe how Ann and Beth worked together to carry out the act of ‘daily meds’ administration as an established routine. As children came in to the health office, the medicine was given, the vial placed back in the cupboard, and the event recorded in the child’s electronic health record. Acting as Beth’s supervisor Ann had seen that they followed a similar pattern to safely administer medications. The redundancy of the activity served to enact it as a daily routine that contributed to the possibility that these students would continue to be in their seats in their respective classrooms.

Along with tablets or capsules other forms of medications were also administered. The most common were the non-oral medications for managing asthma. Children that regularly used inhalers to control their asthma also arrived at regular times for administration of their medicine. Ann frequently encountered children with poor asthma control arriving with breathing difficulties that presented her with educational opportunities. She regularly taught them what they needed to know as she also helped them administer their asthma control medication.

The nurse through directly supervising children taking daily medications increased adherence to desired daily therapeutic effect and helped to establish habits of

taking the medication on a regular basis (Gerald, McClure, Mangan, Gibson, Erwin, Atchison, & Grad, 2009). Gerald et al. confirmed, in a study of 240 children with poor asthma control, that children in a supervised-therapy group showed greater improvement in asthma control. The school nurse is positioned to daily supervise children with asthma and as Gerald et al. suggest helps these children to reduce the number of episodes when breathing becomes difficult.

During the year-long study Ann had monitored just one child with diabetes, a student enrolled at her other school. Interestingly, while at Wiggle Creek because managing the child's blood sugars had been difficult, she had found herself spending considerable time planning and strategizing for better blood sugar control for the student.

We live in a society that associates giving medications as the primary treatment for the "restoration of health, and the [school] nurse plays an essential role" (Potter & Perry, 2005 p. 822) in the safe and regular administration of it. Others had played significant roles too, (e.g., parents, teachers, district policy makers) to support children managing chronic health conditions to improve the probability of them spending more time in their seat. She did that through educating these other caregivers too as a means to coordinate the child's health care while they were at school.

Ann was resourceful and strategic in dispensing medications to reduce time out of the classroom. Her efforts to provide management of chronic conditions as medical caregiver and as teacher were essential for improving educational outcome. Wiggle Creek Elementary had a 95% average daily attendance rate. (Nebraska Department of Education 2008-2009). The health office was a place for children to come to learn to manage chronic health conditions.

### End Notes

<sup>1</sup>***Pre-service Requirement:*** Statute [71-6725](#) (no date available) and [92 NAC 59-004](#) (no date available) require medication aides to meet minimum competencies for properly and safely administering medication and successfully pass a competency assessment, detailed in-depth in both laws. School staff members are not required to take a course.

***Professional Development:*** Rule [92 NAC 59-004](#) requires medication aides to be assessed no less than every three years in the required competencies.

Retrieved from:

[http://nasbe.org/healthy\\_schools/hs/bytopics.php?topicid=2140&catExpand=acdntbm\\_catB](http://nasbe.org/healthy_schools/hs/bytopics.php?topicid=2140&catExpand=acdntbm_catB)

<sup>2</sup>The administration of medication is a regulated activity. Medication aides may only provide medications under circumstances when a competent individual, a caretaker, or licensed health care professional provides direction and monitoring. The medication aide is responsible to get the *right* drug to the *right* recipient in the *right* dosage by the *right* route at the *right* time (five rights). The individual providing direction and monitoring is responsible to observe and take appropriate action regarding any desired effects, side effects, interactions, and contraindications associated with the medication. Nebraska DHHS medication Aide: retrieved from:

[http://dhhs.ne.gov/publichealth/Pages/crl\\_nursing\\_ma\\_ma.aspx](http://dhhs.ne.gov/publichealth/Pages/crl_nursing_ma_ma.aspx)

<sup>3</sup>2011-2012 Wiggle Creek Elementary School Calendar & Family Handbook is a booklet compiled by Wiggle Creek Elementary for enrolled students and their families.

## **Chapter Six**

### **Physical Health Complaints: “I don’t feel good”**

#### **Introduction**

Two more individuals, Ms. Trenton, a staff member escorting Ben, enter the Health Office. Ann and Beth both notice them. Beth asks: What can I do for you?

Ms. Trenton describes Ben’s toothache. Gathering a tongue depressor and penlight Beth checks where he said it hurt. One look and she escorts him to Ann who is seated at her desk. With the penlight and depressor now in Ann’s hand, Beth asks: What do you think? Ann’s answer: “I’ll call mom to tell her it is time to visit the dentist.” (11/16/11)

This encounter reveals what a nurse can and cannot do in a school setting for children that do not feel well. Ben had been escorted to the health office because he did not “feel good” – his tooth hurt. And, there were expectations of Ann, as the health expert, to resolve the child’s physical problem even before the two arrived. Beth had looked at the tooth first, and realized immediately Ann’s expert assessment was needed. Ann’s words demonstrate her attention to not make a diagnosis. She simply decides she should inform Ben’s parent of his health office visit and her assessment of his complaint. In this chapter, I present a variety of child complaints that were attributed to physical health problems that were considered to be of short duration. The discussion focuses on Ann’s interaction with the children that are ill, and the nursing process that emerges as a



pattern of care. The complaints are organized as the following care categories: fever, head and related anatomy complaints (eyes, ears, mouth), sleepiness, abdominal complaints, upper respiratory system complaints, skin complaints, and injuries. At the end of the chapter, I discuss Ann's care for children that wet their pants at school and unexpected care that she provided.

### **Assessment of Complaints**

In the role of medical caregiver, Ann's response as the licensed medical caregiver arouses curiosity about why she thinks of calling mom as her first response to providing care for the child. What I observed is suggestive of what a licensed medical care provider for children can do and what parents can do for their children – a hint at the complexity that surrounds the role of the school nurse. It is directly reflective of the limitations under which Ann operated as the medical expert providing health care. In this instance, she had checked the tooth and made a note of it in the child's electronic health records. What she had observed as one knowledgeable of unhealthy teeth and the child's description of the pain supported her conclusions – the tooth was infected. But she was limited by her nursing license and what she had found in his health records regarding what she could do for him. In this case her actions would be to call his "mom," and suggest what she thought was best for him – visit the dentist for treatment.

The episode did not end there. Ann also responded to his pain by offering comfort, putting her arm around his shoulders and in a calm soft voice visit with him, asking questions such as: When did it start hurting? Or, does your mommy know about your tooth hurting? These questions served as a means to provide him with her large doses of attention and sympathy. And, they served as a source of information that she

would use when she contacted mom. Ben was sent back to class with the staff member that had escorted him there. Immediately after the two left Ann used his health records to make a phone call to mom. Frequently, when Ann called a parent to inform them of their sick child it resulted in her leaving a message to call her. Unfortunately, in this instance she had to do that for Ben's mom too.

His pain continued and soon it necessitated other responses from his teacher and Ann. Ben and Ms. Trenton returned to the health office. Ann was doing all that she was allowed within her license and her nursing practice skills – comfort in the form of her presence, touch and caring words. (She had no record of parent consent for a pain reliever such as Tylenol.)

Ann had informed me early in the study that she could use some discretion about sending a child home. Ben's tooth had not fit exactly with those described by the district exclusion criteria.<sup>1</sup> Ann's assessment of "may need evaluating by a physician" (Health Services, 2010) was the discretion she would use to send him home. Ben's parents were the only ones that could really do anything about his pain and they were unreachable. Finally her persistence of calling repeatedly the list of phone numbers the school had for him, she was able to contact his mom to inform her of the situation – Ben was sent home.

Throughout the time that I spent with Ann, she spoke often about making a medical diagnosis. Identifying specific health conditions based on more than physical signs was not within her license as a nurse nor was it within what she was expected to do as the school's nurse. In the instance above, she had been careful to assess the physical symptoms that were observable with her penlight and the child's corresponding response to her assessment questions. Later when she would visit with Ben's mom she suggested

that “if it were my child I would take them to the dentist.” Further, she explained that, “We have to be careful with phrasing.” Her attention to what she iterated to “not diagnose” was acting within the district’s policy (in compliance with state rules and regulations) related to the duties of the school nurse. It was the parent’s responsibility to make an appointment with a health care provider licensed to diagnose and treat physical problems. She only suggested that a medical practitioner evaluate the child.

### **Child Visit Patterns**

Children arrived at a steady pace, to receive care for physical conditions and complaints. Throughout the year the number of visits per month ranged from 939-1126 children, and the number sent home per month ranged from 34-60 children. The number of children that Ann and Beth sent home are consistent with the number of children that other licensed nurses also sent home (Pennington & Delany, 2008) The majority of children arriving for care were those needing episodic care; the process of providing care is described below. What they came for varied, but they all received Ann’s and Beth’s consistent care for health related complaints. This pattern was noticeable for each child visit throughout the day. In general, the repeated behavior unfolded in the following steps:

1. Greet the child: Beth and Ann usually recognized the child and called them by their first name. When the child was unfamiliar to them they would ask: What is your name? Or the child was identified by name from the orange hall pass they had carried with them. Ann’s initial question, “What can I do for you?” often was the prompt that would produce the orange hall pass. It had information that helped to explain why their teacher had sent them, such as the child’s name, where they came from, their teacher’s name, and why

they had come as a checklist of common ills that elementary children might experience. It functioned to confirm the child's identity and to access the child's electronic health record to begin the process of caring for them and documenting the encounter.

2. Ask questions: It served as an informal gathering of subjective information.

3. Act on behalf of the child: Objective measures at this stage of the encounter almost always included checking their temperature. Other measures such as a visual examination, asking the child to wash with soap and water, or lying on the cot for five minutes or so for continued observation was within the parameters of objective information gathered.

4. Document visit in the computerized record-keeping program: For most visits information was entered as it was gathered. Their responsibility to document immediately improved the accuracy of what got recorded.

5. End the visit. She had two choices for ending the visit. She either sent the child back to class or sent the child home.

### **Fever Care**

Fever is a common sign of illness. When the child's temperature is elevated, it is a signal that something is wrong; it is a symptom of any number of illnesses caused by bacterial or viral infections. Moments after children arrived in the health office, they were asked: "What can I do for you?" If their complaint was not about an injury, their temperature was checked. It would be one of the first acts of providing medical care. To do that, the majority of the time Ann would stop at her desk, or she would motion with her hand to the child to come to her at her desk, where she would pick up the thermometer and simultaneously say, "Let's check your temperature." Fever is the first

on the list of the exclusion from school criteria (Health Services, 2010). Ann strictly followed this guideline; sending children home when their temperature was 100 degrees or more. On most occasions when Ann checked a child's temperature it was not elevated.

Further, in her effort to engage children in their care and to make the act of checking temperatures a learning opportunity, she would often let them see the numbers that were displayed. If the reading was normal, she would announce, "that was a good temperature." Just the news that they had a "good temperature" was enough to distract them from why they had come in the first place.

While checking temperatures was routine for complaints that were not about an injury, sometimes it indicated that the child had a fever. One day, in the first week of March, Lucy, a third grade child, had a fever. Beth noticed her when she entered the health office, and asked, "What can I do for you, Lucy?" She stopped at Beth's desk and told her, "I don't feel good." Beth's immediate response was to check her temperature; it was above 100 degrees. Looking into the child's eyes, Beth asked, "Do you want to lie down on one of the cots?" Lucy nodded her head up and down in agreement. Beth added, "I will call mommy to come to get you." She checked her computer screen and then made a phone call to mommy. Lying down on one of the three cots provided a place to rest while Lucy waited for mom or dad. Usually someone was available to come to get their sick child. On that day that was what happened for Lucy. Ann then asked Lucy to go back to her classroom to get her things and to inform her teacher that she would be leaving. If Ann had additional information for the teacher she would add it to the orange pass that Lucy would carry with her to get her things.

Other times the phone number that Ann called had no one answer. Then she would leave a message to return her phone call, and immediately call the next number on the child's contact list. Sometimes Beth and Ann worked together to get children sent home. Several times I witnessed no one answering the phone number listed as a parent contact. Since parents are required to list emergency contacts for when they are not available, either Ann or Beth would start calling these numbers or simply call the parent again. On occasion they will enlist the child to help them contact someone to take them home. Sometimes the children provided new numbers that had not been reported to the school yet.

Once a parent of a sick child was contacted, Ann used several means to communicate the situation to the parent. A printed form duplicating the phone information was given to the parent when they arrived to take their child home, along with a quick conversation confirming with them what had already been said on the phone and printed on the form. A quick conversation with an arriving parent might signal the possibility that language may be a barrier in communicating clearly. The written information would be helpful to parents learning English. The printed document further served as a resource to help inform parents of what was expected of them, and about when their child could return to school.

Sometimes Ann had special knowledge of where parents might be at a particular time. For example, one day in April when I arrived, I noticed two girls seated beside each other on one of the cots. A few minutes later both mom and dad arrived to take them home. Ann had known that Mary and Debbie's parents had been at a parent meeting that regularly met on Wednesday, and was able to contact them there.

It was interesting to watch Ann continue to provide care for the two girls even in the presence of their parents. She began helping Debbie, the five year old, with her coat by zipping it, and asking her if she was ready to go outside. While it was routine for children to get their coats and backpacks in preparation to go home, Ann had noticed that Mary, did not have a coat. Because Mary only had a hooded sweatshirt, she asked her “Don’t you have a coat?” Her efforts to get them ready to go out in the cold continued to support her efforts of caring for them while they prepared to go home, and the parents could see that.

For children with a history of fever, but who now appear symptom free, and have returned to school, the questions that Ann might ask relate to what has happened at home. For example, Mira, an older elementary child, entered the health office and stopped at Ann’s desk. Ann quickly greeted her, “What can I do for you?” Mira answered with, “I don’t feel good.” Because Mira had been absent, Ann asked when she last received a fever reducer, and then was given permission to lie down on the cot. Mira’s temperature was not elevated, but Ann asked her to keep the sleeve of the thermometer for later temperature measuring. She would check Mira’s temperature again before she left for class.

A fever would alert Ann to the fact that Mira may still have an infection, which would make it necessary to send her home again. Checking the temperature of all children helps Ann to assess if children are infected with germs that are contagious. Sending children home with a fever helps to protect other students from also becoming ill. Even when they are sent home, when they return they may still be contagious. Ann’s

assessment of the child health's status provided for a safe environment for the healthy children and to care for the needs of a child that may have returned to school too soon.

I never witnessed Ann teaching children about why they had a fever. This was unusual because I regularly observed and listened to her specifically teach them about other health conditions that they had come to her for help. I suspect that her reason for not teaching about a fever had more to do with how the child felt when they had a fever and she knew that children needed to be healthy to learn; this was not a teachable moment.

### **Headache Care**

Headaches were common complaints of children when either Ann or Beth asked them, "What can I do for you?" they usually described it as a headache rather than the general "I don't feel good." That initial question meant an offer to help with the pain they must have felt in their head, a pain that was distracting them while in the classroom.

Just as Ann and Beth had followed protocol for all other complaints, they also interacted with the child complaining of a headache in a face-to-face individualized manner. Ann's experience and professional knowledge helped her to ask the right questions when she began her assessment of a child presenting to her with a headache. Beth had received training to ask those same questions.

Children complaining of headaches also had their temperature checked. Through the years, she had recalled that checking the child's temperature was one of the tools that she had available to her to assess a headache that also worked magic for children. In recalling cures for headaches she guessed that the thermometer ranked equally with ice packs and Band-Aids to cure what was distracting them in the classroom. Simply put,



Ann had said, “We have three things that work magic: 1) check their temperature; 2) ice packs; and 3) Band-Aids. While Band-Aids were not used for headaches, checking temperatures and placing ice packs on foreheads were the most often used ways to treat a headache. Other interventions for the child were time to rest on the cot for further observation or given a pain-reliever such as Tylenol.

### **Assessing Headaches**

To assess a child’s headache complaint, Ann asked questions that would help her to gather information about their headache. When she did that Ann typically held the child’s hands and looked into their eyes. As I watched the dialogue unfold with Annie, I noticed that she was holding her hands as they talked. When she was satisfied with this preliminary information she had gathered through Annie’s answers to her questions, she said, “Let’s check your temperature.” Then, she asked a series of additional questions: What class did you come from? What have you been eating? All of Annie’s answers would help Ann understand the child’s headache and tailor her response to it. Finally, Annie was asked if she wanted to lie down on one of the cots for a five to ten minute rest. The five to ten minutes that Annie spent resting on the cot was additional time for Ann to continue observing her, and decide what to do for her. After ten minutes of resting Annie was asked one additional question: Do you want to go back to class? She was ready. Ann watched as she walked out and said, “Bye, bye.” Annie had spent time resting on a cot under the watchful eye of the school nurse; it had been what was necessary to get the child back to her classroom.

**Administering a pain reliever.** After ruling out a fever, her questions turned to ones that would generate information to help her make an assessment of the child’s

condition. These questions followed a pattern that elicited answers to describe the environment of their recent past – even into what occurred during the weekend. Other than what she asked of Annie, I noticed that other children complaining of a headache were asked other questions: When did your head start hurting? (If at home, does mommy know?) Where does it hurt? Do you hurt anywhere else? She listened to the children's answers; she sometimes typed notes in the electronic health record (mostly she added them later). While adding to the electronic health record she might also notice if there was parent consent for giving the child a pain reliever. If the consent were there she would ask if they wanted to take the pain reliever that she had parental consent to administer. Most children that were asked if they wanted to take medicine wanted to do that. However, she did not always ask; she knew these children well. Mostly it was her doses of attention, sympathy and a little time alone on the cot that would act just as effectively as any pain reliever.

However, Ann was allowed to give a pain reliever when the parent consent was noted in the electronic record and the child agreed that they wanted it. Ann noticed Joshua come into the health office, as she did I noticed that she was looking up information on her computer. After greeting him she asked, "What can I do for you?" Joshua said his head hurt. After a brief silence she said to him, "I can give you some Tylenol. Which do you want? Liquid? Chewable pills? Come over here, let's weigh 'ya'." Together they walk to the scale and then back to the locked cupboard where the formulary medicine was stored. She measured out the liquid in a tiny clear plastic cup. After he swallowed the medicine, he filled the cup with water to drink and started to walk

out of the room. In a lighthearted way Ann speaks to him, “No, no that cup stays here; put it in the trash. I don’t want to see you in here any more.”

Early in the study, Beth had told me that she or Ann were authorized to dispense “formulary meds such as Tylenol, or Ibuprofen” only if there was a parental consent form on record.” She explained, “students can be given five doses per month of these formulary medicines from the health office.” This is a useful policy in that it keeps students from going home. Ann clearly was familiar with Joshua’s coming into the health office, and had a record of it. Her records served as additional information that helped her to assess whether he should be given Tylenol. Her professional knowledge, additional information she had gathered from this encounter, and past health record information were of value to keep Joshua in the classroom.

Those that do not have permission for pain relievers would most likely be asked if they wanted to rest on a cot for a few minutes. During their rest time, Ann would continue to assess how severe the headache was by how well they rested. This additional information can enlighten about other conditions the child might have (e.g., a cough). When she did not note anything significant in the ten minutes of resting on the cot, she would then ask if they were ready to go back to class. Most were. Her efforts at multiple levels – physical, mental and social– were helpful to get children back in the classroom. They had entered with painful expressions on their faces, but left with smiles.

**Giving Water.** On hot days students complaining to Ann of a headache seemed to increase. On one unusually hot spring day, five children had passed through the office in about 10 minutes complaining of headaches. While some children may have just been hot because of their rigorous activity in the sun, Ann treated each child with respect and

individualized doses of attention. Her interaction with the children reflects an assumption about her held beliefs. The children had come with a physical complaint that was important to them, and she responded with that same importance of their need.

I noticed on one warm spring day two children, Adam and Tom, enter the room. When Ann asked, “What’s the matter?” The two boys both complained that their heads were hot. “Who is first?” she asked. Adam said he was. First, she checked his temperature and said that he had a “good temperature.” Because she knows that he has been outside in the heat she asked, “Have you been drinking water? Did you eat your lunch? Did you hit your head? You have two choices: 1) get a drink; use the paper cup and fill it twice and lie down on the cot or 2) get a drink and go back to class. Adam wanted to go back to class. Both Adam and Tom were given the opportunity to drink water. Since neither of the two boys had an elevated temperature, and she was satisfied with their answers to her questions to make an assessment of a headache she determined that all that was needed was to drink water. Arriving in the health office for care of a headache avoided behavior in the classroom that would contribute to difficulty for both Adam and Tom attending to instruction. The outcome of these two encounters contributed to the two boys going back to class with an improved capacity to learn.

Most of the time, when children arrived complaining of headaches, they had a variety of circumstances to describe that had caused them. Ann’s years of experience and her professional knowledge led her to associate the relationship of exposure to heat and the play of children at recess with in an increase of headache complaints. While her quick assessment of the child may have led her to believe he needed water, her

assessment was also based on individual attention and a reliance on her professional knowledge and her past experience caring for other children.

### **Care for Head Injury**

Just moments later, Cheryl arrived complaining of a headache. Through her questions Ann gathered valuable information about how she had bumped her head. These nuances gathered as accurate information in the questions that she asked of the children and documenting it in their health records served as valuable information if headaches did not resolve on their own. Cheryl was given an ice pack and sent to class. However, she was told to return if her head continued to bother her.

Ice packs, when used with authority worked magic for headaches and bumps to the head. It was her most often used treatment for pain associated with head injuries. After she gathered the details about their head injury she would give them a choice about treatment - an ice pack or not.

Also, Ann's questions about the action that led up to the injury was a quick way for her to determine if the incident was an accident and whether the child could safely stay at school. Finally, she followed up with instructions about applying an ice pack to the injury site, and instructions to tell mom about the incident. Whenever a child received a head injury she always notified parents of it. She would also inform them of what to watch for if the injury was more serious.

Sometimes a bump to the head happened at home. When children complained that their head was hurting because of something that happened while not at school, Ann investigated to determine how serious of a bump it was. One day late in April, Paul, a kindergartner, told Ann about the bump to his head that he got at home. In a soft voice,

she asked questions about his head while holding both his hands as they talked face-to-face. He described his head as hurting after he fell at Grandma's. After a direct look at where it hurt, she asked him, "Do you want an ice pack?" He did. As he left to go to his classroom, she said, "Tell mom that it still hurts."

Her professional knowledge of children and their responses to bumps that happened at home, and complaining of it at school had helped her to determine that, in Paul's case, ice was all that was needed. It had worked magic for her to give him doses of attention and sympathy to relieve his pain. Then the ice had made it better. Her caring for him had benefitted him in such a way that now he was ready to go back to class and focus on learning. If not, he would be back and she would follow up with care that was needed then. In all cases of headaches and bumps to the head she knew they would be back if the pain did not go away. In addition, as part of caring for a head injury she always followed up with a phone call home to inform parents that the child had come to her complaining their head hurt and described to them what she had done to help.

### **Eye Care**

When children arrived in the health office complaining that something was wrong with their eye, it usually was described as "my eye itches," "my eye hurts" or "I can't see." When this occurred, Ann would draw the child close to her to have a direct look. If they presented with the affected eye tightly closed and/or a hand covering the affected eye, she would offer her sympathy and concern turning to questions about their eye once she had established trust and confidence that she would help them. Patiently, she would coax children to remove their hand from covering their eye to open it so she could have a look.

### **Use of Ice Pack**

When eye injuries occurred at recess, a child would arrive escorted by a staff member or another child. Often Ann used humor along with providing care. She did that with Charlie, a fifth grader, after he came to her with one eye closed. Immediately, after she noticed him enter, she straightened in her chair and folded her arms, then quickly leaned back in her chair with a sigh of relief, “Oh my gosh it didn’t fall out; you are going to be all right? Do you want some ice?” From her experience and professional knowledge, she knew that showing her “crazy side” would bring a smile; it would help distract Charlie from his eye hurting. She had already made a quick assessment to determine that what he had come for was not urgent; his relaxed body language had communicated that. He walked directly to her, and for a while they had a quiet conversation. The complaint was from recess when he had gotten hit with the tetherball. Ending the conversation she asked a question that would provide treatment for his eye, “Do you want some ice?” He did. Together they walked (her arm around his shoulders) to the freezer. He was sent back to class. The cooling effect of the ice would help with any discomfort (real or imagined) that could distract him from learning.

### **Use of Water to Wash**

Sometimes the complaint was about accidentally getting something in the eye. To assess the complaint she had to first convince the child to open their eye(s). Children, as response to an eye injury, held their hand tightly over the injured eye and/or closed it tightly. Her comfort and sympathy to gain their confidence that she would help them was the first act of caring that most likely occurred to voluntarily open the eye. In cases where the child had gotten something in their eye, an accurate description of what occurred could determine what she would do. I observed the act of washing an eye

several times. Sometimes the children were capable of doing it themselves. When Ann determined that the child could wash their eye, she would instruct how and supervise them doing it. To add additional comfort she frequently sent them back to class with an ice pack.

The day that Caleb and Keith entered the health office complaining that each had accidentally gotten squirted with hand sanitizer describes how she ‘washed eyes’. From her questions she determined that Caleb would use the sink to wash his face and Keith would get his eye washed. To do that Ann had him lie down on the cot. She prepared him by asking him to help her. She had him place several folded paper towels around on the cot by his head and gave him several towels to hold in his hand. She had him close his eyes. After she had added water drops to each eye, she said, “Now let me see; blink, blink, blink and blot.” She repeated the process. To her instructions, “Now let me see” he automatically opened his eyes for more of the water to get into his eye. Later, as we talked informally she shared that she had learned this technique when she worked on the pediatric floor of a hospital. For her, it was much easier then trying to hold the eye open. With the child lying down, the water gets on the eye when opening and blinking. This approach removed the fight with the child to keep the eye open. As a creative licensed medical care provider she had managed the incident with low-level technology.

### **Use of Eye Drops**

Eye drops for itchy eyes that have no other symptoms (i.e., inflamed, red and/or drainage) were treated similarly with a drop of the health office eye drops (a sterile solution that was mostly water). When she determined that drops would be helpful, an



act that was more symbolic medical care than it was medical care, the child was asked to lie on one of the cots. What occurred was similar to Keith's eye washing.

The eye drops had no medicinal purpose other than to serve as a wash. Yet, because a trained health care provider administered it with authority it would be enough to help children return to class not distracted by their itchy eyes. Children with itchy eyes were asked to return if the problem persisted.

Sometimes, when children complained of itchy eyes, it was not clear what the child was complaining about. In most of those cases an adult would arrive with them to help the child describe what bothered them. A first grade student, Sammy entered the health office rubbing both eyes. Beth greeted him, "Hi, what can I do for you?" He did not respond with words. Beth continued to talk to him and said, "when you rub your eyes you can't see well." The language educator, Miss Linda arrived to check on him, and she watched as Beth asked him to read lines on the eye chart – no errors were noted. Beth again tried to get answers to her questions that would help her to assess what to do for his eyes. He used so few words that it was difficult to determine why he was in the health office. His teacher and Beth decided he should go back to class. He left the room with his teacher. The case was complicated by the fact that he was new to the school and very shy. This added to the difficulty in describing his physical complaint. Fortunately, Beth was fluent in the language he spoke at home, but he still had few words. To get him to answer her questions she tried both his home language and English to get him to describe his itchy eyes. Then she talked with him offering her doses of sympathy and comfort for his itchy eyes. Her assessment determined that his eyes did not appear to be inflamed nor did she observe any drainage (exclusions from school criteria). Beth and

the educator attempted an informal conversation with him to see if they could determine how to help him. In the end, they decided he was having multiple adapting problems and the itchy eyes were a result of rubbing them. Beth knew would return to the health office if the problem continued.

### **Ear Care**

Another health concern that children complained of and sought Ann's or Beth's care was that their ears hurt. When it came to ears hurting I noticed that children came to the health office seeking care because of a possible infection. Rarely, at least on the days I observed, had it been for any other reason.

Only Ann looked in the children's ears when they complained that they hurt. When Ann was not there to have a look, Beth would ask the child what she could do for them. In either case the child's temperature was checked and documented in the electronic health record. After checking the child's temperature, and if it was normal she would give them some ice. Sometimes the ice worked its magic to make their ear stop hurting other times it did not. Beth knew they would soon be back in the health office if their ear continued to hurt.

When Ann was there she would ask them to come to her for her to have a look in their ear. In doing that, she was careful to continue talking to them, usually in a soft comforting voice offering her sympathy and comfort. I noticed that when she talked with Joey it included teaching about healthy ears, and why she was doing what she did to care for his ears. For example, she talked about her looking at the good ear first. She asked: What would happen if I looked at your bad ear first? Would I spread bad germs to the

good ear if the one that hurts were looked at first? She looked at his ears, and told him that the painful ear looked red. She told him to tell his mom when he got home.

She repeated a similar scenario on another day with another child complaining of an earache too. The care for Sally's earache was similar to Joey's. For Sally, she comforted her by commenting "Let's take a peek at it. Then the questions begin: When did it start hurting? Which ear hurts? Which ear should we look at first? Why should we look at your good ear first? Sally did not answer, so Ann explained to her that she did not want to spread germs from her hurting ear to her good ear. While she looked inside the ear she commented, "That's about the prettiest ear I've ever seen. Tell mom if it continues to hurt. It is a tiny bit red"

After Joey and Sally left the room Ann contacted each of their parents by phone to inform of what she had observed. In Joey's case, she explained to his mother that she was not able to see well in his ear because of wax, but it did appear a little red. And continued by adding, "if it were my child I would take them to the doctor. He may be getting an infection."

### **Head Lice Care**

Occasionally a head checked for lice would be positive. In Billy's case Beth did find head lice. What I found interesting was that Beth did not need words from the child, but rather relied on the note to determine what she would do. Once she confirmed evidence of head lice, she removed one (probably a nit) and taped it to a paper that was being sent home. The paper explained to the parent (along with the phone call) what had been found and what they were expected to do. Beth was simply following district protocol for head lice. It was one of the conditions that children were excluded from

school (Health Services, 2010). It is generally understood that lice do not spread disease, but they bite because they need blood to survive. When they bite they cause an itchy scalp and they may contribute to other problems (American Academy of Family Physician, 2004). When one child in a classroom was found to have head lice, it was the nurse's responsibility to check all of the children in the classroom for nits and lice. Her findings would be reported to individuals on a need-to-know basis.

### **Tooth Loss Care**

Children in elementary grades (ages 6 -12) lose their baby teeth, thus Ann and Beth provided care to children that had lost a tooth. Most children that arrived with this complaint had the tooth in their hand and wanted a special tooth box to keep the tooth in. Beth typically was in their line of vision when they entered the health office so she would ask, "What can I do for you?" To answer her question the children held out their hand to show her the tooth. To that she would ask: What color of box do you want? Ann and Beth had several colors to choose from: pink, orange, red, yellow, blue, or green. Once the box selection was made, the tooth was placed in it. Before leaving the room with their tooth safely in a special box in their pocket they were asked to wash their hands. While they did that, their orange health office pass was signed, and they were sent back to their classroom. This too was recorded in the health record.

Sometimes a child would arrive with a loose tooth and obvious bleeding. When that occurred Beth sent them to the restroom sink. One student, Sara, arrived, said nothing, but pointed to her mouth. She walked immediately into the restroom. After awhile she came out. Beth noticed and said, "You pulled it? Wash your hands." The

tooth was put into an orange tooth box. Beth checked to see if her mouth was still bleeding. It was not and she headed back to class.

### **Canker Sore Care**

Occasionally a child would come to the health office complaining of canker sores hurting. Ann recalled that she used to see more cold sores (outside the mouth) than canker sores. Sometimes she would “call a parent to visit about possibly getting the medication that was available for treating the sores. I just want them to have the information that I know about for treatment.” Daisy came to her one day in Mid-April to show her the canker sore she had. Ann took a look at her sore and asked her questions about it. “Do you want to rinse with salt water? It looks like it is about to go away. How long have you had it? Do you have salt and water at home? Do you do this at home (reference to rinsing mouth)?” She listened carefully for answers to all of her questions. When Daisy finished rinsing her mouth, Ann asked, “What is your last name?” Ann signed her orange pass and sent her back to class. I found it interesting that Ann had to ask Daisy for her last name. Daisy had been one of the children that rarely came to the health office. Ann and Beth would have screened her for height, weight, vision, hearing and possibly dental health (she may have seen a dentist in the past year). That would have been in the fall; it was now mid-April. They knew most of the children’s first and last names without asking, especially those children who came often for health care. Daisy had not been one of the children that frequently came to the health office. They were available to her, and she had found their care useful on this day.

### **Care for Sleeping in Class**

As a health expert, Ann is knowledgeable of the relationship between adequate amounts of sleep and positive education outcomes. She described the symptoms as falling asleep in their classroom seat, being cranky, and having difficulty with thinking clearly (i.e. functioning poorly in the classroom). When these sleepy symptoms occurred in the classroom, teachers noticed and sent the affected students for a visit to Ann.

One day in early April, Ben came to her complaining that he was tired. She glanced at her computer screen and knew immediately what she already suspected. Ben was making a habit of coming to the health room to sleep. She said to him, “You have already been in the health office four times today.” He had no response. She asked the same questions that she asked the four other times he had been in to see her. What did you have for lunch? He knew what was next. Ann told him, “I’m going to have you lie down for five minutes.” While he was lying on the cot, we both noticed he was asleep. He was allowed to sleep, but he woke up approximately 15 minutes later. When she noticed that he was awake she asked, “Who picks you up?” She continued to gather more information related to his sleepiness with more questions as she sat beside him on the cot. She checked his temperature. While she did that she talked softly to him, ending the conversation with her instructions, “You take another quick nap.” Ann walked to her desk to enter his data into her computer, and then walked back over to him, and asked, “What do you think we should do? Her final question creates a teachable moment to relate his current health status with his behavior. Ann regularly gave children the opportunity to make choices about what should happen next in caring for their health. It was her way to teach responsibility and management of their health. Classroom teachers also have this responsibility to teach about management of health issues. Perhaps when

Ann taught students health skills, the caring relationship she established with the child and the privacy that the health office provided enhanced the possibility that learning took place. As a health educator in a public school, I noticed specific health issues that children struggled with, but did not always have the opportunity to create the privacy that the school nurse in the health office regularly utilized.

Since it was late in the school day, her question “Who picks you up?” drew his attention to the possibility of her informing mom and dad that he was sleeping in class today. Ann believed that sometimes children did not want her to tell their parents. Doing that would inform them that they had not gone to sleep but rather had played or done something that prohibited them from sleeping.

Sleeping in the classroom is troubling to her. Her goal is to keep children in their classroom seats, but some are too tired to do that. Through an informal conversation Ann shared her concerns. She informed me that besides it being a problem in class it was tricky to help them. Her experience supported that sometimes they were sleep deprived and sometimes they lacked motivation to stay awake. She believed it was important to consider the child and their home environment. For some, she believed that they had not been able to sleep because of noise at home. She described it as, “For example, big brother may have come home.” In the instance above, her “record keeping – name, what wrong, time, what done - all entered into the computer made it easier” to identify the frequency, especially when she was thinking “good gravy how often [have they] come in?” The computer can quickly answer.” Unlike Ben, when there is no past record of wanting to sleep in the classroom, she allowed the children to sleep about an hour and then woke them up. “One hour of sleep helps for when they go back to class; they will be

more likely to function in the classroom.” Her experience had taught her that less than one hour of time for sleeping did not help alleviate symptoms associated with sleep deprivation.

Falling asleep in a busy room, with a continuous flow of people and the noise from their conversations, would make it difficult to fall asleep if you were not tired. I noticed that most children who complained of being tired did not fall asleep and were sent back to class.

Once her observations confirmed that the child was sleep deprived, she utilized their health records to determine how often the child had been in for a nap, and any other information that was noted in the record. A healthy school age child no longer needs an afternoon nap when they are well rested. If they are not well rested, sleeping for approximately one hour in the nurses office was what she had found worked to get them back in the classroom and not returning to her.

Sometimes sleepiness is a symptom of illness. After Steve rested on one of the cots for 15 minutes, Ann asked are you ready to go back? Steve said, “yes,” but his body language clearly said he was not OK. Then she questioned him: “Does your tummy hurt? Does your head hurt? Do you want to rest a little longer?” I noticed his head nod in agreement. He rested five more minutes. After 15 more minutes of sleeping she woke him up, and checked his temperature again. This time she asked, “Would you like some cool water on your face? His head moved side-to-side confirming that he did not want to put water on his face. Ann signed his orange pass, and then she said, “You need to return to your class.”



Even though this encounter took place early in the fall, Steve was a child Ann had known well. She commented to Beth that he rarely came to the health office. Her assessment using all the information she gathered led her to suspect that he was sleepy because he was ill. However, he did not have any of the symptoms that would cause her to send him home, so he was sent back to his classroom.

While sleeping is not a reason for the nurse to send a child home, when it occurs as a symptom, concurrent with a temperature over 100 degrees, vomiting, diarrhea, persistent cough, or a skin rash, the sleepy child would be sent home (Health Services, 2010). Ann's case-by-case assessment of children, using information that she gathered, helped her to determine if the sleepy child should be sent home. When it was still not clear, Ann allowed them time to rest five to 60 minutes. This rest time can help to determine what she can do to help. It is an individual decision based on the facts that she has gathered. Sending them home does not keep them in class; her role in assessing the child's needs improves the possibility that they will be in their classroom.

### **Gastrointestinal Care**

Gastrointestinal upset is a common daily complaint in the elementary health office (DiMario, 1992). Wiggle Creek Elementary is no exception. Tummy aches contributed to the health office being a busy place with children arriving on a regular basis. Not all actually vomit, mostly they come because their "tummy hurts," or the children described it as, "I don't feel good." When they did vomit, Ann's policy was that an adult must witness it, and then Ann could send the child home. Sometimes it was Ann and Beth that witnessed it; other times it was more complicated. A child reporting that they had vomited in the restroom was not evidence to be sent home, as far as she was

concerned. Her experience had taught her that children were not always forthcoming about that they had vomited. Nevertheless an adult would need to confirm that vomiting had occurred.

### **Going Home: Contacting Parents**

Once there was evidence of vomiting, Ann would begin the process of sending the child home. The process involved calling parents, sending the child to get their things, and telling their teacher they were being sent home. Once that was done, she expected them to wait in the health office until mom or dad picked them up.

Occasionally, when a child had vomited, Ann and Beth would work for several hours attempting to notify parents of their sick child and that they would need to take them home. When this occurred Ann acknowledged that she was “thankful the child didn’t have something worse, something life threatening.” While an occasional child continued to vomit, all they could do, besides continuing to offer large doses of sympathy, comfort and keeping them away from other children, was to wait for parents to take them home.

Towards the end of the day, when illness merited that a child be sent home, she might suggest they wait in the health office for school to dismiss. Her experience had taught her that parents were probably on their way to school or not at home anyway. She would explain to a sick child that it was all most time for school to get out, so they were welcome to wait with her or if they wanted they could go back to class – she let them decide. Her instructions for what to do about tomorrow included “If you feel this bad tomorrow stay home. This is not like you. You must really be sick.”

### **Teachers Notice**

Ann described getting help with tummy troubles often begins with the teacher noticing that the child just isn't itself. Teachers and other classroom staff spend hours with the children and can identify when the child acts differently. And, then once in the health office, since she was not privileged with spending long hours with the children, she relied on her nursing practice skills and experience to know the right questions to ask. Ann did that.

### **Tummy Ache Stories**

In general, the initial assessment began when the child arrived in the office announcing that their tummy hurts. It was immediately followed by her questions, "Did you eat breakfast?" (Most children that arrived in the office in the morning were asked about breakfast later in the day she would change the question to did you eat all your lunch?) Did you sleep well last night? "When did it start hurting?" "Did you get hit in the stomach?" or "Did you throw-up?" The order was contingent on the child's answers and further questioning added to what information she had already gathered. Her quick thinking would prompt her to ask other questions that further helped to provide for the child's needs. Once she finished with the questions, she almost always (exception was a child with a more urgent need arriving) added information to her computer while the child stood next to her.

It happened repeatedly through out the day and on some days more than others. What varied was how the children entered to present their stomachaches to her. Brad presented his stomachache escorted by his teacher, who walked beside him carrying a wastebasket filled with papers. After arriving in the health office, she grabbed an empty wastebasket by Ann's desk. Ann's greeting was physical – she put her arm around

Brad's shoulders and ushered him to an empty cot. She carried the wastebasket. Once he was lying on the cot, Ann sat beside him. She asked him her standard stomach questions: Did you eat lunch? Did you get hit in the stomach? Brad's answers helped her to understand his response to his upset stomach, and helped her respond with appropriate care.

In Brad's case the adult carrying a wastebasket was a clue about his physical complaint. Any mention of impending vomiting by a child produced similar scenes on other occasions. Interestingly, classroom teachers seem to respond with more urgency than either Beth or Ann did. As a classroom teacher, my experience had taught me that vomiting in the closest wastebasket was better than vomiting on the child's desk. It was easier to get both out of the classroom – vomit and child. Ann and Beth took it all in stride. Their quick visual assessment of the child provided clues to what was likely to happen next. I never observed any of the children vomiting as they arrived.

Immediate care was situating the sick child on a cot with a health office wastebasket beside them. Next, they might send them to the restroom to see if that helped. Sometimes it did; sometimes it did not. At this point Ann might lighten the situation, such as talking about how much kids had grown since she had last seen them. Her ability to distract them often was all that was needed. Then when her light-hearted conversation produced a smile, she knew that they were feeling better. They were given their hall pass, and would leave for their classroom.

On a day that there was more than the usual number of children complaining of tummy troubles, I observed Beth wiping vomit off of a small child's jeans. Children were welcome here no matter how they presented themselves. Teachers knew that ill

children would be cared for in the health office. That was what the adult's body language seemed to suggest as she ushered Brad into the room. A sense of relief was hinted at as she arrived without his vomit all over. Ann's ability to focus on the care of an ill child with compassion and respect (it is humbling to vomit in the presence of someone else) helped her respond as a caring nurse.

### **Other Ways to Care for Tummy Aches**

From the time a child began telling her that they had come because they did not feel well, her response had been consistent. She would first allow for information gathering, a question and answer phase of the encounter. Ann made sure that the conversation was a face-to-face one; it was what characterized her nursing practice to create dialogue that allowed her to share her empathy as the two searched for an understanding of what was in the child's best interest, and for her to create a relationship of respect and appreciation of them as individuals (Noddings, 2005). She kept the conversation light hearted and upbeat offering just the right amount of sympathy, to ensure that trust was established. It was natural for them to interact close to one another; it promoted dialogue in which a soft, kind and friendly voice was expected. It created a presence that might be described as a loving parent or grandparent talking to their child or grandchild.

Greg is another example of Ann interacting with a child complaining that his stomach hurts. When he walked into the room, I noticed that his arms were crossed on his abdomen as if he was "holding it." He stopped by Beth's desk; she was talking on the phone, so he waited there. Ann noticed him and motioned for Greg to come to her. He did. Her extended hand brought him close and invited him to tell about his tummy. She

asked her usual questions: When did it start? Did you eat breakfast? Then she reached for the thermometer and said, "Let's check your temperature." They waited for the thermometer to beep, when it did she reported the exact number she saw recorded on the device. With her arm on his shoulder, she asked, "Do you need to use the restroom?" He did. Her actions and her questions for Greg were the ones she had asked others so many times before. And just as she had done for others she listened as he answered her questions. Together her actions and questions that created dialogue were how she once again established a caring relationship between the two of them.

Further, children were given an ample amount of time to describe their pain. The most common objective measure that she utilized was to check their temperature. When it was normal or they were not vomiting she would often ask them to use the restroom. Sometimes it resolved their complaint. If it did not, she would ask them if they wanted to rest on the cot for five minutes or so. This too was a nursing tool to allow her additional time to continue her assessment, in Greg's case, his abdominal pain.

Most children wanted to return to class. Once nothing new occurred the child was sent back to class. However, sometimes evidence (vomiting or elevated temperature) was gathered that warranted that the child be sent home. When that occurred, they gathered their things and waited in the health office. Then, because she wanted to visit with the arriving parent and give them an informational paper for why their child was dismissed from school, she would make herself available when parents arrived.

Tummy troubles were noticed to come in clusters. In mid-May, shortly after lunch, I noticed groups of children arriving with the same stomach complaints. First three children came into the room together; all described having stomachaches. Ann, thought

for a moment, walked to the middle of the room where the three children had stopped, then said to them: “You are one; you are two; and you are three. Ya all know where the bathroom is?” Looking at each one for an assurance to do what she had suggested, “each of you lie down on a cot for five minutes, close your eyes, and no talking.” She positioned herself at her desk and began calling them up to her to find out about their health care need, and to give them that large dose of attention and sympathy that she regularly dispensed to all who arrived for her care. She said, “OK who is number one?” The child she had given the label of number one got up and walked to her desk. As she talked to him, I noticed her extend her hand to draw him close. She again used her soft, voice to ask: Did you eat lunch? When did your stomach start hurting? Did you get hit in the stomach? This action was repeated for the other waiting children that had been assigned numbers two and three. Once she completed her assessment, one by one she entered their answers into her electronic records. In this instance, after checking temperatures, a trip to the restroom and a short rest, all of them were sent back to their classrooms. Visiting with a health authority and the magic that a short rest can do was all that they needed to get back to their classrooms. Furthermore, their encounter with the school nurse had assured the children that they were healthy and needed to return to class. Not only her authority as a medical expert had convinced them of that, but also their participating in an interaction where they were cared for and appreciated as an individual were what was needed to keep them in the classroom.

**Tracking possible contagious disease.** After the above children were sent back to their classroom, a little while later four more children came complaining of stomachaches. Ann noticed the occurrence of another group arriving and asked “are you

all from the same classroom?" I too noticed that these children were all about the same size. To answer her own question she checked their hall passes; each was from a different classroom. When the numbers of similar symptoms becomes apparent and those symptoms fit the criteria for exclusion Ann's responsibility is to take note of it. However, once symptoms are documented in the electronic records her supervisor has access to that and monitors the numbers that are presented at any given time. As an added assurance of monitoring contagious diseases Ann would also contact her supervisor to report what she had found. When reportable, Ann's supervisor contacts the State Health Department with the number of ill children. On this day, Ann was probably a bit troubled by the numbers of students complaining of a stomachache and the few that had vomited, but it was her electronic records that would be the source to determine the significance of it. She said that when 10% of the school's population were ill she would contact her district supervisor to bring it to her immediate attention and to her principal's attention too.

**Care for constipation.** Besides a contagious gastrointestinal illness causing an increase in children's stomach complaints, other circumstances or conditions could account for what had occurred. Ann's professional medical knowledge and experience working with elementary school age children made her keenly aware that constipation ranks as a common reason for abdominal pain (Borowitz & Cuffari, 2011). Thus it was prudent for her, after checking a child's temperature, to ask children if they had to use the restroom, and if they did not want to she would suggest they try anyway. Frequently it made them feel better. Children arriving with abdominal pain were routinely sent to the restroom. Many times that was all that was needed to resolve their pain.



**Care for hunger.** Other times a tummy might hurt because the child was hungry. For these children she kept cereal and milk (a weeks supply) in the room's refrigerator. Her gathered information helped to determine what would be most helpful on a case-by-case assessment. When hungry children arrived complaining that their stomach hurt, asking if they had eaten helped to give them relief. When children had not eaten they were allowed time in the health office to eat cereal with milk on it. Interestingly, all children at Wiggle Creek were allowed to have a free breakfast before classes started. They did not always take advantage of that opportunity.

Others had not eaten, and still were not hungry. Beth and Ann expected children to eat breakfast. Because the expectation was to eat breakfast, children were given the opportunity to eat whether they ate or not was their choice. Not eating for long periods of time could certainly have been the reason for stomach pains. Ann used her knowledge of what children liked to eat to have a supply of favorite cereal available that would appeal to most children. Eating a good breakfast was an important part of what she could do to keep children in their classrooms.

**Care for social issues.** Sometimes stomachs 'hurt' for reasons that might be attributed to a child perception of their social and/or emotional environment (e.g., a child's schedule and/or how they felt about it). Ann's face-to-face encounters often uncovered feelings that might be causing stomach distress. For example, a child might come to her acknowledging that their stomach hurt, and while assessing for physical symptoms (e.g., elevated temperature) she would help them to talk about other problems. Ann regularly related to the children seeking help for a physical problem on multiple levels. For example, Betsy had a problem with a specific learning time in her classroom.

She arrived in the health office walking and almost skipping to announce that her stomach hurt. To make her assessment of why her stomach hurt, Ann asked her appropriate stomach questions: “Did you eat your breakfast?” “Why don’t you try going to the bathroom?” Betsy comes out of the restroom to announce it didn’t work (reference to a bowel movement). To that, Ann suggested, “Let’s have you lie down for five minutes.” She did this happily and willingly. Ann told her, “I’ll set the clock.”

In less than five minutes Betsy was asking to go back to class. While she rested on the cot, Ann had asked about her day. Aware of Betsy’s schedule Ann already knew what was causing her ‘pain’. Sure enough at just the right time Betsy realized that enough time had passed since she left her classroom that she needed to get back there. She did not want to miss reading. Ann documented the encounter in Betsy’s health record. If she needed to investigate why Betsy had come, she had her electronic notes of the encounter. As Betsy left, she had quick steps (almost running). To her quick exit, Ann asserted, “Walk, walk with your arms folded.” (A behavior you hear school staff reminding students to do on a regular basis.)

Acting within the scope of nursing practice, Ann had cared for children with gastrointestinal complaints. She utilized nursing tools such as the thermometer to assess for illness; she also utilized asking the right questions to gather valuable information about the physical complaint and to gather other valuable information that had been related to why a child’s stomach hurt. When the stomach complaint was not associated with vomiting, Ann was able to send children back to class.

### **Upper Respiratory System Care**

A sore throat, runny nose, and a cough are symptoms of upper respiratory

illnesses that are common among elementary age children, especially in the winter months. And, just as with headaches and tummy aches children were good at describing this ailment's symptoms too. Typically, children that had a cough in class entered the health office coughing loudly as they announced why they had come. Those with sore throats often entered appearing afflicted with something serious. Ann recognized "the look" and used humor to determine how ill they were.

In general, I noticed that she drew them close to engage in a caring relationship while the child described their cough or sore throat. Her nursing tools (tongue depressor, penlight and thermometer) allowed her to make an assessment of their throat. Once she had a look at their throat or listened to their cough she would ask: "Would you like to gargle? Her follow-up depended on her assessment of the appearance of the child's throat and the sound of the cough. Sometimes she got out her stethoscope to listen to their chest. If she saw physical indications of a strep infection or heard abnormal chest sounds she would contact the child's parents. However, when she did describe her assessment to a parent she was careful to describe the appearance of what she saw or heard. She was careful how she worded her conversation with them. She informed me that she might phrase it this way: "If it were my child I would want the doctor to have a look." If the child complaining of a sore throat or cough also presented with a fever, the call to parents would be for them to take their child home. She would also inform them of her other findings – usually suggesting they be seen by a physician.

Sometimes children with a cough or sore throat arrived in the health office for a cough drop. District policy allowed the nurse to administer cough drops only when parents had supplied the cough drops and had sent a note to document that the nurse

could give the lozenges to their child. Any prescription medication for sore throats or coughs were administered by the nurse following district guidelines (i.e., doctor's prescription and parent consent to administer at school.)

Typically a child was not sent home from school because they have a cough or a sore throat. In some cases, Ann's assessment of a cough or sore throat uncovered conditions or symptoms that warranted the child be sent home and/or parents be informed (Health Services, 2010). Coughs and sore throats are symptoms of respiratory illnesses and an elevated temperature might indicate the presence of an infection (e.g., influenza, strep throat, mono).

### **Rash Care**

In the spring, Ann noticed an increase in conditions such as scabies, insect, and dog bites. When a child with a rash arrived in her office she always assessed each one individually, and she provided comfort and sympathy. I noticed that children with rashes or spots that itched did not present with as dramatic illness behavior as did the tummy complaints. Even though that may have been true, Ann did not change her response to children with rashes. She always maintained her caring manner in support of children's health. A rash or bug bite can itch intensely and make focusing on instruction difficult at best. Her professional medical knowledge and nursing experience would need to support the action or treatment she would use to keep the child in their classroom or excluded to protect the other children.

While it was not within the scope of her practice to diagnose diseases that present with rashes, she still found it challenging to distinguish between rashes that were a symptom of a contagious disease and those that were not. She described that many

rashes/or itchy skin were from contact. In that case, children were asked to remove the item thought to be causing the rash, and the skin was cleansed. Because she wanted to be sure the rash was caused by contact and not something else the child was asked to return for her to have another look. In addition, she always reminded children to “tell mommy about your rash” and reminded them to not scratch it.

Sometimes her anti-itch lotion was smoothed over the affected area, other times she covered the affected area with an adhesive bandage or an ice pack was placed on it to reduce the itchiness. When children were sent home with serious rashes parents were instructed to bring a doctors note to the health office when the child returned to school. She reminded me that for Wiggle Creek children, a trip to the doctor was most likely at no charge. (She was referring to the number of children receiving free health care. There was a medical clinic within walking distance of the school – three or four blocks away.)

Insect bites were challenging. Some bites, especially when there were multiple bites, could be confused with contagious diseases such as chicken pox. When a child presented with confusing symptoms it would take Ann’s expertise to discern the difference between the two. In the middle of May, Tonja, a fourth grade student came to the health office to show Ann some bites. Her teacher, Ms. Fine, accompanied her to the office to tell Ann that Tonja had not had the chicken pox. Ann looked closely at the affected area, and asked, “Do you have bites in other places?” Ann’s professional knowledge of rashes helped her to determine that the lesion pattern was not typical for chicken pox, and suggested that what she saw appeared to be bug bites.

### **Cuts and Bruises: Minor First Aid Treatment**

Cuts, bruises and bleeding were common in the health office. And, for most of them the process of cleaning the wound, and applying an adhesive bandage and ice were all that were needed. Ann's expert care in attending to children with this type of physical complaint had a high success rate of sending them back to their classroom.

### **Recess Injuries**

Cuts and bruises noticeably increased when it was recess time for the children. One could even tell what grade level was having recess by the children entering the health office. Ann's role, when it came to administering minor first aid, was to respond to both the injury and the child's response to it. Most injuries at Wiggle Creek were minor, but the child's response to it might not be. To respond to minor injuries, Ann initiated proximity (e.g., extending her hands for the child to hold on to while she talked softly, sometimes it was a hug) while they sobbed out the story of what happened, they would walk together to the sink to wash a cut or bruise. Often she would say, "I'm sorry you got hurt." That seemed to help Jenny. When she arrived crying, and noticing Ann's arms extended to her, she extended her arms too and ran to Ann. Once the two embraced, the sobbing slowed. Ann talked softly face-to-face with her. She calmly asked, "What happened sweet heart? What happened? Ann wiped her tears, "You have beautiful eyes." Where do you get such beautiful eyes?" Jenny managed an answer in between sobs, "From mommy." After the sobbing stopped, Ann suggested she put ice on her injury. But, she asked her first if she wanted an ice pack. She did. Since no blood was noticed, Jenny (with her ice pack on her injury) and her teacher left the room.

What is interesting in this interaction between a nurse and her young client after a minor injury incident is Ann's response to naturally want to comfort the child. The child

senses that too and runs to her. Ann continued to talk to her in a kind, compassionate way - one that quickly soothed her. Ann looked into her eyes, and serendipitously was able to bring mom into the conversation. And, as the encounter concluded she gave the child a choice about her treatment. An act that helped her to feel in control of what happened to her.

Jenny's injury was not serious. The ones (one of them had been her teacher) that had witnessed it had decided she was able to walk to the health office for nursing care. Sometimes when children got injured on the playground the adult supervisor determined that the child should not be moved. When this happened another child was sent to get either Ann or Beth. Beth, as a trained school health technician, was positioned to respond to emergencies. Ann was comfortable delegating assessment of injuries to her. When Ann was there when a more serious injury occurred, it would be an opportunity for her to observe Beth responding to critical needs.

When a report came that the nurse was needed for an injured child, Ann began the assessment immediately through the window by her desk. (She kept the blind up so she could see the children playing.) In late May, when that happened, Ann looked out her window to get a direct view of the situation. Beth went to the playground to help. Moments later, Beth, Ms. Jenner, and Clancy arrived in the health office. Clancy continued to cry. Ann greeted them, got an ice pack, and positioned herself beside Clancy on the cot. Using her soft voice she spoke to Clancy and began her assessment of the pain and what might be injured. Her assessment determined that she should be sent home.

Beth contacted Clancy's parents to describe what happened, and why it was determined that she should go home. In this instance, mom arrived quickly. Clancy was helped out of the room by mom and Ann – they both had their arms around her.

It was tricky to make a definitive assessment of injury without diagnostic tools. Ann was respectful of the district's criteria and did not make a diagnosis. Her effort was directed towards the child's reaction to the injury. If she had noticed serious injury (e.g., broken bone) she would suggest that the child be taken to the doctor. Anytime comfort and sympathy did not have a calming effect, it was concerning, and Clancy's lingering tears helped Ann determine the need for her to spend the rest of the day with her parents. Both Beth and Ann thanked Clancy's mom for coming so quickly. For some reason, second grade recess has been dangerous that day. Four other second grade children had also come to the health office with injuries.

### **Physical Education Class Injuries**

Sometimes injuries happened in physical education class. When that happened, Ann and Beth would respond with their comfort, sympathy and first aid treatment. For example, ice was applied to the injured area and sometimes it was determined that rest on one of the three cots was needed. Some children were quickly calmed, while others were not, but they all left calmed and cared for. A careful examination of the injured area was always done first. This was followed with treatment of ice to the injury. When an ankle or leg injury was assessed ice was applied and rest on one of the cots was required to determine if they could be dismissed back to class. While the children rested, Ann and Beth would continue to dialogue with them, it was necessary to building their caring relationship.



**Other Musculoskeletal Injury Stories**

It was interesting when children arrived in the health office with their own diagnosis. Jerry had done that. He came to Ann to tell her that he broke his hand and he could not move it. In her usual matter-of-fact manner, Ann asked, “What happened?” She listened to his answer, and offered him an ice pack. A half hour later Jerry was back; this time with his teacher. This time Ann said, “If it falls off, I’ll sew it back on. You can pick the color of thread.” He smiled. After exploring why the student’s hand hurt, he was given ice and sent back to class. Ann explained that if he needed to he could come back after lunch for more ice. She instructed him: “Keep moving it to help reduce the swelling.” She asked again does your mother know that you hurt it? He said she did. His teacher apologized for not knowing that he had already come for Ann’s care.

Teachers notice when children are not themselves. In this instance, Jerry had already been in for the nurse’s assessment, and he was given ice to relieve the pain and swelling. Ann had a record of the event. When he arrived again, this time with an adult, Ann had re-examined the injury, asked appropriate questions and used humor to resolve the complaint. Her subjective and objective assessment had determined that ice would help with the discomfort. Then along with more ice authoritatively placed on what hurt, she instructed about when he should come back, what to do to help heal the injury, and her additional sympathy and comfort. Her expert care, the use of humor, and the fact that his teacher also knew what was being done, the hope was that Jerry would stay in class, comforted and ready to learn.

For Ann, it was a puzzle why children chose to present to her and Beth in the ways that they did. Regardless, a repeated pattern of both Beth and Ann responding with

a concerned greeting, appropriate questions to get the child's story, their assessment based on visual examination, documenting the episode and preparing the child to return to class (some were sent home) were salient throughout the study describing skeletal injuries. Humor, or her crazy side as she liked to describe it, was a useful strategy to get some of the children back to their classroom.

### **Band-Aids & Bleeding**

Besides ice packs on injuries, Ann also used adhesive bandages to treat injured children. Both worked magic to heal the cut or bruise and to get children back into their classroom. Teri's mosquito bite illustrates the magic of Band-Aids. He had come to the health office with his teacher, Ms. Riner. Beth acknowledged their arrival with her usual greeting question, "Hi, can I help you?" Ms. Riner explained that Teri needed attention for a mosquito bite. Ms. Riner requested a Band-Aid and added, "I hope we can see it; Teri thinks it will help her behave in the classroom. Beth applied the adhesive bandage. Teri smiled.

Teachers have adhesive bandages in their classrooms to use on occasions such as the one above. In late August, I watched Beth prepare the supply for all classroom teachers. When I asked her what she was doing she explained that the health office supplied teachers with first aid for bleeding. To do that they each received a clear plastic bag filled with a hand full of bandages and latex gloves. Then, to distribute them, she would place them in the teachers' mailboxes. In the incident above, removal from class into a controlled environment such as the health office may have provided the dosages of

sympathy and attention that the child needed for a bite that itched, even if it was mostly symbolic in nature.

Other times, the adhesive bandages served their intended purpose of covering an open wound and to control bleeding. From analysis of my fieldnotes, patterns emerged to describe it. In general, after initial doses of sympathy, comfort and prevention of blood getting on clothing, the bleeding site was washed. Most children were asked to do this for themselves. While they did, they were supervised and instructed to use soap and lots of water. They were also instructed in drying the injury. Ann was vigilant in helping them and consistently told them to, “wipe it again, if it is wet the Band-Aid won’t stick.” Whether it was bleeding from an injury, a scab that came off too early, or a hangnail the Band-Aid did its magic; when they returned to their classroom the assumption was that the child would be able to refocus on instruction and stay in their seat. If not, another trip to the nurse would be in order.

### **Care for a Bloody Nose**

I observed the most copious amounts of blood coming from bleeding noses, a common occurrence in school age children (Kucik and Clenney, 2005). When Ann noticed a child walking into her office with their hands holding paper towels to their nose, she would attend to them quickly. In bloody nose cases, she would immediately begin with instructions to get the bleeding stopped. Repeatedly she directed them to “pinch your nose and wait three minutes before you peek.” Children with little bleeding were instructed to have a seat and pinch for three minutes. Then she monitored for proper nose pinching. If she found that they were not pinching properly she instructed them in the proper way. When there was a larger amount of blood, perhaps some on clothing, she

would walk with the child and help them to a chair to sit down. With her gloved hands (gloves always went on her hands when she cared for bleeding) she removed the paper towel they arrived with, replacing it with gauze to place over the nose to pinch. Then, depending on the child's reaction to the bleeding, she would sit with them. While she sat with them, she visited about their day, clothing that she found interesting that they were wearing or anything she thought of to distract them and to provide her initial doses of care and sympathy. After three minutes all hands were washed and clothes checked for blood.

### **Care for Other Bleeding**

Ann had learned early in her nursing practice that getting rid of the blood on clothing or elsewhere was helpful in calming children. Her experience with children that were bleeding was that they were scared at the site of it. She found that hydrogen peroxide worked wonders to remove spots of blood on clothes. She liked making it interesting for children as she meticulously searched their clothing for splattered blood, telling them "this stuff likes to eat blood." Most blood was washed off with soap and water. But, that varied too depending on the reason for the bleeding. Most children were capable of washing wounds with Ann supervising.

My fieldnote enlightens from both a medical and educational perspective. I noted that an older child, Donna, wanted Ann to look at her heel. Ann asked, "What do you think we need to do? Wash your foot?" Ann had already determined that first the foot must be washed, and it was in Donna's best interest for her to wash the foot, rather than Ann to do it for her. Because she was an older student, Ann used the context to teach her responsibility in caring for a common occurrence such as a blister. Ann prepared the

space. She seated Donna on a short stool, moistened a gauze pad with warm water and liquid soap, and then gave it to Donna along with several paper towels. She sat beside her throughout the time it took to care for her heel blister; adding instructions and interest as Donna washed her heel. For example, Ann said, “Can’t you hear the germs saying don’t hurt me?” Shortly after that she added, “Girls are braver than boys.” Once Donna had dried her heel, Ann applied an adhesive bandage to the blister. Donna put her sock and shoe back on.

When Donna was ready to leave, Ann suggested, “Here lets put some Vaseline on your lips. You are licking your lips: what do they taste like?” She listened to Donna’s answer and sent her back to her classroom. Ann frequently applied Vaseline to children complaining that their lips hurt. Noticing Donna’s chapped lips and applying the Vaseline treatment before she would complain to her teacher that she needed to visit the nurse helped to limit time spent outside the classroom. Vaseline treatment for chapped lips was a frequent occurrence especially in the winter months. Either Ann or Beth placed the ointment on a Q-tip, and the child applied it to their lips.

### **Wetting Pants Care**

A child wetting their pants was also a regular occurrence that fits in the category “I don’t feel good.” Wet clothes are uncomfortable, and it is generally a traumatic event when it happens in the presence of your peers (Daytime wetting, 2011). When teachers notice a child is wet they send them to the nurse. Beth and Ann both responded to them with patience and understanding. The child was supplied with clean clothing – either they brought their own from home or the health office supplied clothing.

As the school's nurse, Ann was responsible for keeping a supply of extra clothing. Beth regularly gathered the supply (some of the items were used and some were new) that they needed from a stocked closet located on the top level of the school building. However, when children got their clothes wet from recess – puddles or snow – a hand held hair dryer might be used to dry the child's wet clothing. Even though she was able to obtain a variety of clothing for children to change into when they were wet or soiled, she was conservative in passing out clothing. Instead of replacing clothes that failed to get returned for others to use; their original clothing wet from recess, was dried and the children were sent back to class.

When children were supplied with clean clothing, Ann consistently reminded them to tell mom to wash the clothes they borrowed, and instructed them to bring the clothes back to school. When children did not return what they borrowed, the supply dwindled and they had to wear whatever was available. Sometimes the clean clothes fit well; sometimes they did not.

### **Miscellaneous Care**

On occasion, children arrived to have things other than their bodies cared for. For example, in late spring, Ann worked on a pink flip-flop that was broken. Just after she commented, "This needs some really good glue" she left the room and returned with some glue from the main office. The flip-flop was quickly glued and given back to the owner.

Another time, it could be tangled hair. One child, Suzy had entered the health office requesting that either Ann or Beth cut off a tangled piece of hair. She was offered

a comb to use to remove the tangles, and sent to the restroom with a mirror to do what she could.

No matter what health care situation was presented to them, from serious injury to minor health complaints, the health office staff responded to give direct care that was needed. Besides the medical care (mostly symbolic) that Ann provided, the children also received large doses of sympathy and comfort throughout their encounters with the nurse. And, it was delivered in a calm and methodical manner.

Ann provided all children arriving in her office an opportunity to tell her about what had happened or what their need was. She intuitively knew that some had come just to get out of class. She had an arrangement with Ricky, a first grade student to do that. He would come to see Ann looking sad but not crying. Slowly he would walk to Ann. She would extend her arms to reach for him and lift him onto her lap. The two would talk quietly. In a short time, he would hop down from her lap and walk slowly to a cot. She reminded him, "In a minute I'll check your temperature." After a little squirming around on the cot she asked, "Are you ready to go back to class?" He was. She would put her arm around his shoulders and walk him to the door. Then he would get one more hug, and he left for his classroom.

Later she informed that Ricky had trouble with one particular subject. He frequently came at this time of day. She believed that his teacher had figured out that allowing him to come to the nurse helped him to come back to class ready to learn. His use of the health office for respite, a kind of relief from the pressure to learn, was a useful strategy for him. When he arrived back in his room he would be ready to figure out what seemed impossible. The strategy was a better choice for him. Instead of acting out in the

classroom and then being punished, missing instruction time and getting farther behind, he simply spent quiet time with the nurse and returned to the classroom picking up where he left off.

### **Comments**

Teachers at Wiggle Creek knew that a child sent to the health office would receive attention, comfort, and sympathy along with an assessment from a medical expert to determine their health status. Besides when they were in the health office they would also benefit from health instruction that was face-to-face in the context of receiving the medical care that met their specific needs. For example, teachers had first aid supplies to help with bleeding, but a Band-Aid applied by a medical expert such as Ann would supply what was needed now to refocus on learning and instruct about caring for open wounds. And, when it was health concerns that needed an expert's care, Ann would address, intervene and manage the case to a successful resolution. Most of the time, that success was sending them back to class. Other times it was in the best interest of the child to be sent home. It not only helped the ill child to recover, but also kept the environment safe for others.

### **ENDNOTES**

<sup>1</sup>Exclusion Criteria for the district appear below, and have been copied from:

<http://www.lps.org/stuserv/health/excriteria/default.html>

#### **Guidelines for the Dismissal of Students with Health Concerns**

1. The student with a temperature of 100 degrees or more.
2. The student with an undiagnosed rash/skin lesion. (Exception: If the student is taken to a physician, he/she may be readmitted with the doctor's written permission stating the



rash is not contagious.)

3. Head lice.

4. Other conditions that may warrant a student being sent home include:

- Inflamed red eyes and/or drainage
- Vomiting and/or diarrhea
- Frequent persistent cough
- Earache and/or drainage from the ear
- Questionable illness or injuries, which may require evaluation by a physician
- Sores that appear infected or are draining

## **Chapter Seven**

### **Tracking Health Information: “Let’s Get You in the Computer”**

#### **Introduction**

Throughout the clock watching and waiting, Ann stands close to Pricilla and waits with her hands on her hips. While she does, she also asks her questions and listens to Pricilla’s answers. Ann says, “Now lets take another peek.” They agree that the bleeding has stopped, and she instructs her to wash her hands and face. While the student does that, Ann says, “Let’s get you into the computer.” (2/8/11)

This was not the first time that I watched Ann attend to a child with a bloody nose. A bloody nose and the first aid treatment for it was an often-repeated act (See chapter six for more discussion.) that I observed in the health office. The fieldnote above was selected because of Ann’s succinct description of her role to track health information – “Let’s get you into the computer.” Tracking information was associated with everything she did. She was required by her nursing practice, school, and district to document what she did related to health care. She described it as her “busy work,” not a negative phrase, but rather one that she referred to as taking a considerable amount of her time. In this instance, it was documenting the encounter she had with Pricilla. For Pricilla’s health record, it would include selecting computer generated common language to describe what occurred, and following links that resulted in an electronic record of the episode.

Ann spent a significant amount of time tracking a variety of health information as Wiggle Creek’s school nurse. For example, she documented daily encounters with children when they arrived for their daily medication and when they arrived for caring for

their physical complaints. Whenever she encountered children and adults alike, it was documented in the individual's health record. For Pricilla, she documented the nosebleed and described the treatment received.

On most days, when I arrived, two things were noticeable: 1) a child was being cared for, and 2) Ann was situated at her desk typing on the keyboard of her computer. It repeatedly served to remind me that the majority of Ann's time was spent tracking information, while Beth, the health technician, cared for the children. Ann consistently documented what had occurred in the health office into the computer. When I arrived, I did not always know what information she was tracking; I made it a habit to ask her what she was working on.

As we talked informally, Ann informed me about tracking health information at Wiggle Creek Elementary. She knew that the school had been using the current electronic records for about two years. Besides discussing what was documented with each visit and other electronic options available, such as create parent letters, and access to immunization and screening records, she summarized electronic record keeping as documenting encounters with anyone in the Wiggle Creek school (staff and children) who enter the room for help with a health related matter.

This chapter acknowledges the information tracking that was discussed in chapters five and six related to child visits, and extends the discussion to other ways information tracking closely tied to student health and education. Creating a detailed description of the school nurse tracking health information, warrants that it be conceptualized occurring as a sequence of events (phases): 1) gathering/generating information; 2) recording information; and 3) reporting it. She reported to the affected

children and their parents, to other nurses, and to the teachers and administrators and finally to her nursing supervisor. Each phase of tracking health information is significant and merits a separate discussion to create the account of what a school nurse does in her effort to promote health and improve education outcome for all children while they attend school.

### **Health Records: Background**

Along with caring directly for the children, it was also within the districts guidelines that Beth document health information. Ann and Beth worked closely to accomplish all three phases of maintaining health records, but it was Ann's responsibility to see that the student's health records reflected current health status and then to use that information to promote health and education.

A cumulative health record for each child is maintained as an electronic record and as a manila folder filed in one the filing cabinets situated close to her desk. Besides the child's name, cumulative health records contained identifying information, contact information, and health history information (e.g., immunization records and important information such as allergies, and any medical conditions). Further, the records also consisted of documentation of health assessment data and narrative. The manila folder held paper documents that others had supplied to update the health record. Inserted items might include, but not be limited to, parent consent forms, written doctor's orders and care plans with pertinent health information (Nebraska Health and Human Services, 2004). What she gathered was driven by school policy and nursing practice.

Record keeping (information tracking) provided her with documented information to communicate with others about the child's health and education needs for such things

as immunization compliance, individual therapies, and education plans while they were in attendance at Wiggle Creek Elementary. For example, her ability to examine her current records of all grade levels for each child's status of immunization was instrumental in her achievement of assessing all children for compliance. It had still been a demanding job as she neared the district's noncompliance exclusion date for state required immunization. She had estimated at one point, in early fall, that record keeping was taking up 90% of her time. While her time was consumed with immunization compliance, Beth had been instrumental in the continuous care of the children.

### **Privacy Issues**

The records that Ann maintained were considered school records, but they were also considered health and educational records. In schools, privacy issues are covered by both Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule. Ann understood the privacy provisions of both of these acts. She explained it this way:

We cannot pass on a child's health information to other schools outside the district without parents written permission except for immunization history and school physicals because these are required to enter into another school. Most schools, including my district, have you sign a form requesting all information from the former school so all the information can then be forwarded at that point. (12/5/11)

The fact that immunization history and physicals did not require parent permission emphasizes the school nurses role as a public health care professional. When a child entered a new school, it was the responsibility of the school (i.e., the school nurse)

to protect all their students from contagious diseases. The record the previous school supplied assured the child's new school of the protection that newly enrolled students had against certain contagious diseases.

### **Maintaining Health Records**

Maintaining health records is conceptualized as a process. The first phase discussed is gathering or generating health information. The other two phases are interpreted as distinct phases as well, and the discussion of them completes the process of maintaining health records as it occurred at Wiggle Creek Elementary.

#### **Gathering Health Data**

Gathering or generating information is the initial phase towards accomplishing the task of maintaining health records for all children. This phase usually followed a systematic process. Information generated from individual child visits was either entered as the encounter unfolded or immediately after the child left. For example, I noticed that as she called a child by name she would enter that information to access the child's record. This source of health information was constant. Children arrived regularly in the health office throughout the day; each episode was documented in the computer's electronic records. It was not a paper and pencil process to keep track of confidential information, but rather one that helped to protect confidentiality. Only Ann and Beth had access through their computer login.

Also, there was cyclic health information gathering that Ann and Beth participated in to maintain health records. A significant increase in new information was noticed in the fall. This increase in information was associated with new health data from

students new to the district, compliance tracking for state law required immunizations, and annual health screening (height, weight, hearing, vision and dental health).

In Nebraska, school health screening is addressed in Nebraska Revised Statutes 79-248 through 79-253. Nebraska Statute 79-248 lists hearing, vision, and dental screening. In addition, Nebraska Revised Statute 79-214 and 79-220 address requirements for physical examination and visual evaluation for students at certain grade levels. Further, the authority for the Department of Health and Human Services (DHHS) to circulate rules and regulations regarding school health screening is addressed in Nebraska Revised Statute 79-249.<sup>1, 2</sup>

### **Information Received from Children.**

Most of the health information that children supplied came from when they visited the health office with a health complaint or when they arrived to take their daily medication. Just their presence in the health office prompted data gathering. For example when they arrived with a health complaint it was routine to check their temperature and record it. The child's description of their complaint was summarized into a concise statement that matched an item on a list of computer-generated selections, and added to their health record.

Sometimes children returned completed forms; Ann relied on this too to gather health information that was required to maintain health records. I watched what occurred when Larry, a second grade child, entered the health office carrying an envelope. Ann saw the envelope, and then said, "You brought it back. Here, you need a piece of candy for that. Put it in your pocket for later." He did. Her actions produced his smile. He left with a quickened step. Ann's positive response to Larry returning a required form

suggested the value that she had for the paper and more importantly, the value she placed on his bringing it to her. While I did not know the nature of the information that the paper contained, I did notice Ann's eagerness to enter the data. As soon as the child left, she turned to her computer, looked at the paper and began typing.

Health forms that she can hand to a parent or give to a child to take home are a part of what she is prepared to do to gather information. She had done this with Larry; his parents completed it, and he had returned it to her. The reward, a small token, was safely stored in his pocket. Perhaps it would remind him later how important his actions had been.

Larry's form was but one of the more than 36 different ones she had available to gather health information. Some would be given to children to give to their parents; others were given directly to an adult to supply the information. They all served to help her to maintain health records for everyone at Wiggle Creek Elementary.

**Health screenings.** Screening children for health status began in the fall when she systematically weighed, measured and screened for vision and hearing deficiencies. Most were school-aged children in kindergarten through fifth grade, but she also screened pre-school children enrolled in a federally funded pre-school program.

District health service staff outside Wiggle Creek Elementary coordinated gathering student data from the screening process, but Ann still had some autonomy. For example, she scheduled the screenings with administration and teaching staff, while coordinating it with the district's timeline. She made sure that screening of all children enrolled in federal programs were completed in time for district personnel to confirm that all children had been screened in anticipation of federal authorities review of the district's



compliance to receive federal tax dollars. In short, Ann would oversee that all children enrolled would come to the health office to be weighed, measured for height, and screened for vision and hearing within the first 45 days of school.

***Pre-school screening.*** When I arrived at Wiggle Creek Elementary in early fall, Ann and Beth would be in the process of conducting the screenings. Ann scheduled the youngest children<sup>3</sup> first for their annual health screening. The process began with pre-screening education that consisted of Ann visiting the pre-school classroom to invite the children to come to her room to play a new game. She promoted screening in such a way that the children looked forward to her game. The next day, Beth went to the classroom to ask the teachers for two children to come with her to the health office. She would take their hands and together walk down the hall back to where Ann was waiting. Once they arrived, Beth usually weighed and measured the children. They took turns with screening vision and Ann did all of the hearing screening.

To measure height and weight, Beth first required that the children remove their shoes. Once that task was accomplished, one by one the children stood on the scale. Ann announced, “that is a good weight” or “you have grown.” Her positive statements served to promote health and encourage them, in general, for how big they were getting. After that, the children put their shoes on. Occasionally, the children needed help with their shoes. Next, vision was checked. Sometimes one of the children was asked to sit on a chair or on their lap in order to maintain an assigned spot. Ann was always ready to assist with the vision test or to do the hearing test; she would determine what happened next based on the children’s maturity.

For vision and hearing, Beth would hold the hands of both Bennie and Jakey to guide them to the vision box. At the vision box she asked each of them to name the symbol she pointed to. She listened to the word that they used to identify each. After placing the children one at time at a predetermined distance away from the vision box, she checked their distance vision. Both Bennie and Jakey needed help to cover their left eye first. Ann was waiting and immediately assisted each. The process was repeated for the other eye. Then Ann asked them both to come with her. She introduced them to the audiometer and the sound it made. Placing the audiometer head piece on Jakey (giving both a chance to practice) she said, "Point to the ear you hear the sound."

Because it was early in the school year, Ann paid attention to how children pronounced letters. Her experience and knowledge of the diverse abilities present in an elementary school had taught her that some might not know the alphabet yet. Noticing the pattern of miss naming a letter or understanding directions to respond correctly enables her to make the correct assessment of vision and hearing. They screen every child, but must try again at another time for some. Sammie was one that would be re-screened. Sammie entered the health office accompanied by her teacher, Ms. Lawson. Sammie had difficulty standing still on the scale without touching nearby objects and parts of the scale. Beth wrote a note of both her height and weight. Next, with one eye covered, Beth asked her "what is this?" Beth repeated four times what the letter was, but Sammie was always incorrect. Ann made the determination, "We'll check her vision and hearing later. We always try, someday we will get it." Ann's knowledge of Sammie helped her to determine that it might not be vision deficiencies that caused her to fail the

screening, but rather her ability to articulate the symbols. Ann knew she could repeat her screen later; she would follow up to make the correct assessment.

The process to screen two children at a time was orchestrated to keep the time children spent out of their classroom to a minimum. Once every entity had been screened and the findings recorded on their clipboard, Beth walked them back to their classroom. She would return with two more.

After all of the pre-school children had been screened and the findings recorded, she began screening the children in kindergarten working her way up through the fifth grade. Her efforts would include all children including special education and English Language Learning classes.

For the older children, she arranged the room to accommodate five children at a time. They were dismissed from their classroom in groups or one at a time (classroom teacher determines) and arrived unassisted in the health office. Although quite rare, some teachers sent their entire classes. Ann made accommodations for the number of children that arrived at one time. For example, on a day when she was screening children in groups of five, she had placed the child sized blue chairs along the south wall – resembling a waiting room in a health clinic. Three children were seated waiting; another child was standing in the vision screening predetermined spot, with their backside against Ann's desk and one hand over the left eye. Beth was seated on the cot next to the eye chart. She held the white-gloved pointer to single out letters for identification. Either Ann or Beth placed the lens for near vision over the eyes and asked, "Is this better or worse?" Vision screening was recorded on the clipboard and the child then moved to the hearing screening.

Ann sat at her desk for screening with the audiometer. Interestingly, she whispered the instructions for the hearing screen. (Since the EXCITE screenings she has changed the directions a bit). Usually for the older children she had them repeat the phrase, “I hear it” but today she had changed it to pointing to the ear they hear it with. I watched as a child pointed to the ear they heard the sound when they heard it. I could barely hear her say “Good job” over Beth’s “Good job” for identifying letters in the vision screening that she was doing.

Once a child finished all screenings, they were sent back to their classroom with instructions to ask from more children to come to the health office. Two more children entered the room as the others were leaving. The process started all over. It worked smoothly; Ann and Beth were flexible. Ann’s experience had taught her how to successfully get the information she was required to get from the children, and do it in a minimum amount of time.

Interestingly, between the two of them when a fail was recorded the two would signal each other in a discrete way to keep the information confidential and accurate. Their method of identifying that a child failed was subtle and assured that it was noticed so a recheck would be done later.

***Screening: light-hearted attitude.*** Throughout the process of obtaining screening data, Ann and Beth always had positive comments for the children. I frequently heard Ann tell children, even if Beth had done the weighing saying, “My how you have grown.” Her manner was frequently playful and relaxed while gathering the data especially with the older children. Only on one occasion did she raise her voice to get the attention of a child who had disrupted the process. Her stern voice - something I rarely heard Ann use –

was all that it took to extinguish the unacceptable behavior. The child stopped doing what they were doing and that was the end of it. She would later explain that in the health office they were not about power and control, but rather about building partnerships.

Another time, I noticed Ann singing about hearing; it was a song with the child's name "Let's do your hearing." He looked at her somewhat confused. Her response was, "you're old enough, I'm messing with your mind." He laughed. Humor was frequent. Another time with an older child she had said, "Tell me which one you hear – point." She either did not make sounds in either or had it in both. She laughed. "I'm just playing with you." The student laughed too.

Interestingly, even when she was not formally screening children's height, a child could drop by for a height check. For example, Jonathan walked into the health office with his teacher and stopped by the scale. Ms. Laws explained that he would be having a birthday soon. He wanted to get his height and weight checked to see if he had grown. He was promptly obliged with the same procedure that was used during screening, that is, asked to take off his shoes. Both Ann and Beth complemented Jonathan about how he had grown. Ms. Laws and Ann both guess that he had grown a lot because he was going to be seven. It too was recorded in his electronic health record; the child had come to the health office, he participated in a measurement procedure, and it was recorded.

Children were screened in the fall, unless they were new to the school. It had been several months since Jonathan's height and weight were measured. The social and emotional benefit of Ann suggesting he had grown may have benefitted this child in his classroom. Sometimes it was difficult to know, but there was a record of his height and weight nonetheless.

**Dental screening.** Along with screening height and weight, vision and hearing, dental inspections were also one of the required minimum screening tasks that her district and state statutes required of her (Nebraska Revised Statutes Chapter 79, 2012). She was responsible for managing the dental screening program too. She would plan, assist with screening, and manage the results.

Since the state statutes required health inspections for dental defects and did not allow a waiver option for parents, her task was to first determine who needed dental checks. Specifically, parents had to provide her with documentation of the child being seen by the dentist within the calendar year. If a dental health care provider had not screened a child since December 1 of the previous year, the child would be screened at school (Health Services, 2010).

At Wiggle Creek Elementary, children's dental health was screened through two professional providers: 1) a state dental college; and 2) local dental professional. The dental college worked in collaboration with Ann to screen Wiggle Creek's second and third grade students using funds from a federal grant. Ann's role was to manage the program. Her efforts included sending a letter to parents to notify them of the upcoming program, communicate with teachers the dates and times children would be absent from their classroom, and provide the college with the names of the students participating in the dental screen and sealant program. Ann also arranged for the use of one of the school's rooms for the college to transform into a dental clinic.

One day in early October, Ann took me to see the dental college's clinic set up in the room next to hers. What I observed there was a transformed classroom. It had three

gray dental chairs situated in the middle of the room. Other furniture had been pushed against the wall. As we visited informally about the “dental clinic,” she informed that the next day children would be screened for tooth problems and receive a sealant on their teeth. She estimated that the process of screening for dental problems and applying sealants would take two or three days.

The dental school’s goal had been to screen and apply sealants to 100% of Wiggle Creek’s second and third grade students. Since the second and third grade students would also receive sealants, parents were required to sign and return a parent permission letter. To help the dental school attain their goal, Ann talked to the children about the importance of the parent permission letter and how it must be returned signed – excluding them or permitting them to receive the treatment. Since some had seen a dentist within the last six months they would be opting out of the procedure; others simply just wanted to opt out. Her incentive for 100% of the classroom to return the letter signed would result in popcorn as a treat on Friday.

Working within the college’s timeline had been difficult this year because of the timing of the screening; it had been within days of Ann managing the immunization compliance for the varicella second shot and its consequence of exclusion from school. She would see that both responsibilities were accomplished.

County dental health care providers typically screened children not in second and third grade. To determine the children to be screened by the county dental health professional, Ann had a record of dental health examinations in the health record. Again, she would exclude the children who had yearly dental exams from the dental screening.

The children screened were given a quick 15-second dental screening. Ann's role was to record the dental professionals findings.

In sum, Ann's role had been that of program manager in cooperation with dental professionals to prepare the children and provide the room. Any data she received would be entered into the electronic health records with follow-up for referrals to a dentist communicated to parents. Her effort would generate dental health information for all children currently enrolled in grades kindergarten through grade three and she estimated 70% of fourth and fifth grade students through special programs that required this preventive care were also screened for dental health.

### **Other Data Sources**

While I observed at Wiggle Creek, a difficult and time consuming task that Ann was required to do was to ensure that all children enrolled were in compliance with the states required immunizations. To do that she reviewed her health records, evaluated them for compliance and worked diligently to see that compliance was achieved. Last summer, more than a year before the exclusion date for noncompliance, she identified which children needed the immunization and notified parents of it. Notifying parents of their child's status could be complicated. Ann was aware of the difficulties caused by language barriers. The district has over 30 languages represented. Some languages do not have a written form. Her district required her to identify early and communicate with parents with a language barrier. She would send a note home with their child, or when possible hand the note directly to the parents at Parent Teacher Conferences with an interpreter present. In May, she worried that of the 100 or so students that had not met



the requirement as many as one-fourth would need to be “kicked out” before parents would attend to this responsibility.

In the fall, at the time of the study, Ann had to invest the majority of her time, except on screening days, to gather information from parents or health care providers for the required information that her school records must show to meet compliance with state laws. Her efforts were complicated, and she admitted that, “I’m just cranky with my husband’s health concerns, and other reasons that she had not been able to be at school. “I feel behind.” As manager of immunization compliance, the task rested on her shoulders. During our informal conversations, she shared with me some of the complexity. For example, sometimes there was a difference in health care providers interpretation and her interpretation of compliance with how to follow the state law for every child at the school. Sometimes the issue was the school following state law and the need for a doctor’s written waiver to not receive a particular immunization within a certain window of time. She said she had not had an issue with timing but needed to follow the law requiring the physician’s waiver for another shot.

Ann was aware that children could be exempt at the exclusion date for a variety of reasons. For example, because the shot is a live virus a parent receiving chemotherapy is a reason to wait until the ‘chemo’ is completed. Others might be exempt because the child might be immune compromised and therefore exempt from a live vaccine. Both needed a doctor’s note to delay and re-evaluate for compliance.

Further, Ann, as the school nurse, was allowed to gain access, via electronic health information, to the State Health Department records. As the date to exclude students for not complying with state required immunizations approached, this additional

resource was useful to provide the names of students recently immunized. It supplied her with the information she had needed to update school health records for at least one of the students on her non-compliance list. The student had received the shot, but had not informed her of it. This electronically accessed record from the State Health Department permitted one more student to stay in their classroom.

Initially, the health record is information supplied by parents or indirectly supplied by them, through their consent to get information from another provider. At Wiggle Creek, the school secretary supplies parents with health forms when they enroll each of their children. Completion of the health form at enrollment time is the beginning of the child's cumulative health record that Ann maintains throughout the time that the child attends the school. Parents were responsible to inform the health office when a change in their child's health status occurred. In other words, parents are relied on to keep the school nurse informed of any change in the child's health and conditions associated with those changes. Parents were expected to complete required health forms, were knowledgeable of what information they needed to supply, and were kept current of their responsibility through the district's communication resources. The nurse's office and the district's website were the main source for the available forms and associated knowledge including instructions on obtaining information that the school nurse needed. But not all parents kept themselves informed, nor did they supply or comply with providing health information. It was particularly salient with regard to immunization compliance.

When I began the study in January, Ann had already started the process of working towards Wiggle Creek's 100% compliance with the states newly required

varicella second booster shot. Most of Ann's time was not spent gathering information from parents that had their child immunized, but rather gathering information from parents that had not complied. When parents volunteered the documented immunization records or contacted the health office with recently received immunization, documentation time was minimal per child.

In late August, we talked informally about how she would gather proof of immunization from parents. At that time, she had a list of over a hundred children and their parents to contact. While all parents and children had received notification of the new law nearly a year ago, should would now call parents of children that had not given proof of the second varicella shot. She had used her electronic record program to generate a list with contact information. The plan was to call three times. Each time a call was made she noted the date. After that she sent information home that included a photocopy of the child's immunization record (highlighting what was needed). A fourth call would come on October 5<sup>th</sup> to inform of non-compliance and consequences of exclusion pending compliance. Each time she made a contact, either by phone or sending information home, her list of children still needing the shot was reduced. Her hope was that of those not complying that only about 45 would be excluded from school. She and the principal would work together as a team to get that number reduced. Ann suggested that the principal might catch parents as they brought children to school or picked them up after school.

She recalled that when a measles, mumps, and rubella (MMR) booster was required they had "kicked out a low number of students at the end of this process."

After the exclusion day in October passed she would be the one to notify the principal of children not meeting the state compliance law.

### **Recording Health Data**

The task of recording data was both a distinct task and a task that was imbedded in the act of caring for children. It was distinct when Ann had large amounts of data such as from health screening and immunization record tracking. But when recording data generated from child visits this data occurred blended with the act of caring for children and others that came to the health office with complaints. In particular, the computer had all the Wiggle Creek Elementary children and staff names entered. The names were gender coded: males blue, females pink. When a child arrived, their last name was entered into the system along with their first name. When it appeared in the list with others near by in alphabetical order, the child's name was highlighted and entered. That action produced their health record on the screen. The new screen allowed for adding information gathered from a particular child visit, such as reason for visit, assessment (objective and subjective), treatment, and if parents were called.

**Recorded as received.** Anytime health information was received, it got entered it into the electronic record keeping system the district's health services used. Ann's actions to enter the data were a regular part of her day. This quick/easy access to all of the child's health information provides them with a more comprehensive view, not limited as in their paper records – their old method of tracking health information. For example, while the child was with them for a current health care need they reviewed other information and identified other related health information such as their immunization record and/or screening results. These actions allowed for completion of

any missing screening data (e.g., complete the vision screen, weigh or measure them) or immunization compliance information.

I noticed a system for adding health information. It began with asking the child who they were (locate health record), why they came (enter subjective data) then checking the child's temperature and visually examine (enter objective data), and finally giving the child options for what they wanted to do, such as wash an open wound with soap and water, apply a Band-Aid, and/or go back to class. When objective data (e.g., temperature above 100 degrees) met criteria for sending the child home this was entered too.

Because the health office is a busy place, adding information as it is generated is a prudent process to document accurately and to provide confidentiality. Interestingly, on a November day the electronic records were not functioning as usual. The electronic information was processing so slowly that wait time was so prolonged they were forced to revert to paper and pencil notes. On that particular day, the substitute technician had a pile of child visit notes accumulating on her desk. She was noticeably frustrated. I watched her and Ann stare at their computer screens waiting, waiting – Ann had added: “mine is thinking.” Ann's response had not been at the same level of frustration but rather seeing it in a light hearted way as something positive. For her, it was “thinking.” Later, when the electronic records were functioning properly, all child visits were documented in the electronic records.

Ann regularly made use of printed spreadsheets that contained lists of the children enrolled with hand written columns of data that she had gathered. Her years of experience gathering immunization records and screening data had taught her how to

efficiently organize getting it all recorded in compliance with the late fall deadlines the district set for reporting. The large number of children enrolled (recall she has two schools) pushed her to schedule screening early in the fall semester. Sometimes her careful planning would backfire. She explained that computers are time sensitive and not flexible with regard to when information might get entered. To clarify, she explained it this way, “Last year we entered some health information too early into *Sapphire* and had to do it again. We don’t want to do that again this year.”

**Large amounts of data.** Health screening for height, weight, vision, and hearing generated large amounts of data and required moving the children through the screening process quickly and efficiently. As a result, Ann would have data entered in pencil on spreadsheets that still needed to be entered into the computer. A significant amount of time was involved in checking for any missing data, such as when a child was absent and had not been screened. In the fall, Ann found herself involved in completing the EXCITE health screening documentation. I noticed bright yellow folders stacked on her desk. I watched for a while as she continued to put the folders in a neatly stacked pile. I also noticed a notebook that was open; she referred frequently to it. She was rechecking each child’s gathered data – height, weight, vision (near and far) and hearing status. The review process involved checking computer data for completeness and accuracy. Once that was completed, she carefully stacked the yellow folders into a neat pile on her desk.

Later, another nurse with the district’s EXCITE program would again check Ann’s EXCITE student’s health records for completeness. This process had been necessitated to assure that nothing related to health was missing from any of the children’s records. She informed that missing any required health screen would result in

a “black mark” from the federal government. And that meant funding might be withdrawn. While the process had taken a significant amount of time, she valued the programs benefits for the children and had not wanted to miss any detail.

### **Reporting Health Information**

She frequently reminded me “it really is our job to make sure the kids are healthy.” Her words promulgate her held belief that nursing practice interventions improve the possibility that children will be in the classroom able to learn. Her medical care prevents, minimizes, or removes health problems that contribute to distractions that interfere with teaching and learning. But, as a medical care provider she was limited by district, state and federal guidelines and by her nursing license to what she could do in that capacity. That said, reporting and communicating tracked health information was a significant tool for her to use to improve classroom learning and to manage student health, including acute and chronic conditions, while children attended school. Ann used these school-nursing opportunities to act in caring ways and to create partnerships with children and others that also cared for them. The electronically tracked information helped her do that.

Further, in an educational institution such as Wiggle Creek Elementary Health Office, only individuals directly caring for a child have access to the child’s health record. Teachers and other individuals directly caring for a child such as staff that comprises the student assistance teams (SAT) also have access. Ann explained it as “reporting the information on a need to know basis.” Her district had policies for controlling the manner in which records were shared (Health Services, 2010). As the school’s nurse, she was legally and ethically obligated to keep information confidential.

Ann reported the information in a child’s health records to four categories of

individuals on a regular basis: 1) children, 2) parents, 3) educators, and 4) community care providers. Most of the time when I arrived to observe, I found Beth caring for children, and Ann maintaining health records “doing the busy work.” No matter how she had felt about it, in relation to administering daily medications and caring for the children’s complaints, record keeping (i.e., tracking information) had taken the majority of her time.

**Reporting to children.** Both Beth and Ann regularly accessed the child’s health record in face-to-face encounters. Accessing the information in their health record quickly revealed such things as the number of times they had been to the health office, their complaint, the outcome and parent consent for formulary medications. When it was appropriate, they reported that information to the child. Sharing with the students that she could give them a pain-reliever was a useful tool. When Devon arrived complaining that his head hurt. She was able to determine immediately that she could give him some Tylenol. She told him that, and then asked, “Which do you want? Liquid? Chewable pills? Come over here (walking to the scale), let’s weigh ya.” Together they walked back to the locked cupboard where the formulary medicine was stored. After reading the Tylenol bottle’s label she then measured out the liquid into a tiny clear plastic cup. “I don’t want to see you in here any more.” She concluded the visit with, “Thank you, sir.” Devon left for his classroom. The nurse’s access to his health record to assist her with her assessment, and sharing the information she found with the child helped resolve his headache and get him back to class.

Ann regularly acted in ways that any observer could see that she was making



decisions based on what she had already documented in the records. I suppose the children noticed it too, and had learned to be forth coming about what they told her. In this instance, she quickly accessed Devon's parent consent for a pain reliever. While she looked at his health record, she also was able to review documentation of other visits to determine if a pain reliever was appropriate. While Devon's weight was available to her, she weighed him anyway. Nursing practice requires current weight for administering proper dosage amount. Reporting to Devon that she can give him the pain reliever perhaps helped to build a relationship with him as they worked together to help him with his headache. If he had not had consent for Tylenol, she would have asked him if he wanted to lie down for a few minutes. Another alternative would have been to put an ice pack on his forehead. Children were repeatedly being reminded of ways to manage their health conditions so they could remain in the classroom. This use of the records was consistently utilized for this purpose.

**Reporting to parents.** Reporting or communicating with parents was a common activity that she regularly performed, and would continue to communicate with them until health records were up to date. Prominent to was that she understood two criteria of the school nurse's role: 1) the nurse does not medically diagnose, and 2) only parents and guardians consent to medical treatment. With this understanding her efforts focused on documentation of her assessment of the children when they arrived for her care and on screening data to advocate for children with conditions significant to health or learning.

Her activities in the fall were focused on immunization non-compliance and reporting the results of screening for height, weight, vision, hearing, and dental. She would contact parents of children with any abnormal findings and deficiencies. While

contacting parents might not consume much actual time it still required a repeated effort on Ann's part to inform the parents. This effort involved a repetitious act of gathering data, recording it either on a spreadsheet or recording it electronically and then communicating their non-compliance. Her efforts were not just during the hours of the school day (e.g., during the summer she had spent an entire day making phone calls to parents whose children were not in compliance with state law required immunizations). She would keep in contact with parents until compliance was achieved.

Ann described the process of "varicella work starting ten months prior to exclusion day." During that time it was really a matter of getting the information out about the new requirement beginning July of 2011 encouraging parents to "beat the crowds" and get their children immunized. When she and I visited informally about state law requirements related to the new varicella second shot, she had expressed frustration with her early attempts to inform parents saying, "We know how that worked out."

She had a plan of how she would work with parents to get all children immunized with the required second shot. Just days after school started in the fall, she implemented her plan to report to parents their child's immunization deficiency. She directly contacted parents by phone to inform them again of their child needing the varicella second shot. She explained to me that each phone conversation included the deficiency notice, and the question: Did your child receive the second chicken pox shot? If the parent reported yes, she thanked them, ended the call, and documented the information in the child's electronic record. However, when the answer was no, she asked about an appointment to get the shot. When an appointment date was confirmed, she noted the date on her calendar and reminded them to call her once the shot was given. When parents had taken

no action, she explained the consequences that would result. She then gave them the health department's phone number so that they could call for an appointment. Parents were also reminded to call her after the shot was received for her to update her records. After all the calls were made, her list of children needing the second shot was shorter. Next, she would follow-up by making a copy of the child's immunization record and highlight in orange what was still needed. To that she attached a two or three sentence letter reiterating what was required. The paperwork was taken to the student's classroom teacher to be placed in the child's backpack.

In September, she had created letters weekly for parents. When I arrived for observing she had wanted to talk more about her work to get 100% immunization compliance of all Wiggle Creek children. The process she had of reporting immunization non-compliance and her effort to communicate with parents of children that needed state required immunizations had her frustrated and worried. Some children would need to be asked not to come to school if moms and dads did not see to it that their children received their varicella booster. She explained the problem with contact phone numbers not being current. Sometimes the school was given a number that may not be in use anymore. She could only make contacts with the information she had. Also, calling at the right time was complicating her attempts to contact parents. She said, "I attempt calls at 8 - 8:30 a.m. Before that, we are busy with giving morning meds. A second time I use to make phone calls is between 11 a.m. and 1 p.m. or around 2 p.m. I am careful to explain to others on a child's contact list who I am, and that this is not an emergency. When it is a parents work phone number, I am careful to explain that I am

the school nurse, and that it is not an emergency. I ask them to get my message to the parent to call the school nurse.”

The complications varied for contacting parents. Sometimes she left recorded messages and waited for a return call. Her effort was strategic in that she only made phone calls when it would be likely she would talk with the parent. Throughout the process of contacting parents she also iterated her belief about how parents perceived her calling them. She hoped that the number of calls she had made was not perceived as “stalking them.”

Further complicating reporting was the fact that Wiggle Creek had a number of families that did not speak English as their first language. Any written notice relied on someone being available to read it as written. Her knowledge of this fact helped to utilize a literacy program for parents to learn English that regularly met at Wiggle Creek on Wednesday. She would contact them at school in order to take advantage of interpreters. Her years of experience (this had not been her first attempt to comply with a new state law) made her suspicious that with some of the parents choosing to not learn English. She speculated, “they just don’t want to deal with stuff” and it becomes an excuse to not comply with state law.

In late September, less than a month from exclusion day, the stress of it all became noticeable. When I asked her about how she was doing with the varicella shot compliance, I noticed her straiten up in her chair and her right foot began to fidget. She still had 85 children that had not been immunized. Next week she would run new notices of their deficiency. She would once again investigate about the language spoken at home and solicit help with calling or writing a letter in a parent’s first language.

From the beginning, when the first notices were sent, Ann attempted to determine the language spoken by parents to effectively communicate with them. Sometimes parents made it known that a specific language was spoken in the home. She had access to this information and would do what she could to get the information translated. This applied to making phone calls too. One day in early fall, I watched as she checked on a family's language before making a phone call. She had taken steps to make sure that the parent would understand what she was asking of them.

In the few weeks before the exclusion date the district translators were busy with other schools too. When she determined that “someone else needs to call that one” she would turn around on her chair and refer to the list posted of district languages and individuals to contact for a translation. Interpreters were also district staff that received health information. Their role was a district strategy to communicate with parents, in this instance it was reporting important health information.

As we continued to talk about communication problems, she reflected, “Sometimes I have an older sibling translate for me, but I don't have a clue what they are telling their parents.” For something as important as this, she would prefer to not use siblings. Her experience had taught her that it was not appropriate, especially when the consequences were exclusion from school.

**Reporting to educators.** Ann regularly met with educators at Wiggle Creek as a member of the Student Assistance Team (SAT). Her role at the meeting was as the medical expert representing the child. She described it as “the school nurse providing an interpretation of medical information rather than her providing medical information that was not understood by non-medical staff.” She preferred to present her report in person.

In other words she felt her attendance at the SAT meeting would help others understand how any medical conditions might affect learning.

I noticed she prepared for most meetings by gathering information from the child's electronic records. Sometimes she would call a parent to get information that was not already present in the record or to confirm something she may have questioned. Then she placed it all in her notebook. For example, she regularly met on Wednesday afternoons with the Wiggle Creek Student Services Committee to discuss concerns of any teacher about any particular student. She explained her 'notebook' this way: "I always take my 'screening book' to meetings with educators. In it, I have all of the students screening results. I have it organized by grade. I adopted the forms from one that was already on the computer. This way, when I attend meetings, I'm prepared to share basic health information the educators might need."

Her report was only the medical perspective. Other times her role at educator meetings was that of making sure the information that she had gathered and reported to health services had been reported in their records too. She wanted to make sure everyone had the same information. Her notebook helped her do that too. She admitted, "I usually just go to see what info they need."

At one particular meeting, I noticed some staff came with their laptops. Ann had one, and it would have been useful at this meeting, but she preferred a hard copy of the electronic data. I noticed her checking what was entered as it appeared on the projected screen with what she held in her hand. When it did not match, she spoke up directing attention to any discrepancies that she noted.

On occasion a teacher would arrive in the health office to report noticing a child just was not itself. Ann would then check her records and share documented information on a case-by-case need to know basis. For example, she might check on side effects or adverse effects of daily medication. Sometimes they might not be themselves because their daily medication amount had been changed or the child's behavior was reflective of side effects. Communicating with classroom teachers frequently was the first step in getting health care for a child.

In the spring, new opportunities to inform teachers arose because of what children were doing. For example, fieldtrips were common at this time in the school year. The trips provided special circumstances for the health office, especially for children taking daily medication. It was Ann's responsibility to provide the lead teacher with health information for children with special health needs that would be going on the trip. To do that, Ann had prepared a field trip information notebook listing the supplies to take along. For example, one day in the spring Ann explained to me that the first grade class was on a field trip to a large zoo in a neighboring city. Her role had been to prepare any medications that children would need during the day. She also supplied first aid materials. In other words, the process of preparing for the health needs of the children while they were away from the building on a school day had been systematically completed in advance, were based on health information in student health records, and the information reported to teachers on a need-to-know basis.

In the last weeks of school, Ann also made health records available for summer school health staff. To do that she relied on the school secretary, Joan, to show her how

to make her records available electronically. She admitted that she would also provide a paper list for the summer school nurse.

**Reporting to other schools.** When a child enrolled in another school during the school year, it was her job to send any files that she had to the new school. It was also Ann's responsibility to transfer the fifth grade student's paper health records to the middle school that the students would be attending in the fall. Moving the files involved her first making an appointment with the nurse at the school where most would likely attend. Ann described the file as including "immunization records, evidence of the last doctor visit, pertinent information that helps to know the child." Her reference to pertinent information was to health related documents discussed at the Student Assistant Team (SAT) meetings.

Occasionally, when she had an early report request for a student that would be attending a different school than what she expected, she would deliver the records there too. One of her elementary schools was split between two middle schools that the students would eventually attend. Ann, therefore, delivered records to each of the middle schools affected.

Beginning in April, I first noticed her working on these files. Because getting the files ready to transfer to the next school took more than a days work, I was able to identify what she was working on, and did not need to ask my familiar question: What are you working on today? With this pattern established, I soon noticed her spreadsheet with green and yellow highlighted words. She would study it, then look at the files on her lap, and check off from a list on another document on her desk. She summarized the process as that she was checking to make sure the files belonged to a student still enrolled



at Wiggle Creek, and she was compiling a ‘concerns list’ for the middle school nurse, and in general looking at each file for required documents. Her estimate was that she would spend a total of more than three hours transferring fifth grade health files to the middle schools.

She had been the one to create and maintain the health records for the children transferring to a middle school. If they had entered Wiggle Creek as a kindergartener she would have been the one who had initiated a school health record for them and maintained it through fifth grade. It was not surprising that she was carefully making sure everything was included. She valued caring for them as a medical care provider and as their health teacher. She would want the next nurse to have a complete record of health related issues that the child encountered while at Wiggle Creek. It would be a way for her to continue to care for them.

Sometimes more was needed to continue health care than just the health records. When this was necessary, Ann was responsible for scheduling a meeting to help transition the child into their new fall school environment. At Transition Team Meetings Ann’s role was a medical one again. Depending on the child’s education and health need she worked towards providing the best possible environment for the child from a medical (physical health) perspective.

**Reporting to other district nurses.** Ann cooperated and collaborated with other district school nurses, when she regularly met with them, to enhance nursing practices in their schools. Reporting at these meetings consisted of unidentified student data. For example, at the district immunization meeting Ann’s role was to share what she had done and how that had worked for her in an elementary setting. Her actions provided a means

to assist other elementary nurses in the district. I was able to attend the nurse immunization committee meeting where the question was asked about how plans were progressing for the varicella second shot. I noticed the serious/worried faces of Ann and the other nurses as they discussed getting compliance for the state required varicella second shot. The meeting had been in May. It was not the beginning; they knew the task would become more difficult as the day to exclude children from school approached in October.

At the immunization meeting, Ann shared what she had done and would do later at Wiggle Creek. She expressed her concern for sending a district computer generated letter to parents that the other nurses were considering. She suspected it would not benefit non-compliant parents at Wiggle Creek, and preferred her own letter. Her years as Wiggle Creek's school nurse had taught her that her letter would be most effective. Later, as we talked informally, she shared that her letter would contain only two sentences, not a complicated letter that *Saphire* (electronic record software) generated. And, it would be written at a third grade reading level. She did not want to risk any miscommunication in using words such as 'exclusion' – she feared that not all parents would know what exclusion meant. Her two sentences, in third grade reading level would be sufficient to inform parents that the varicella second shot was required by state law, and that the consequences for non-compliance were that their child could not come to school.

**Reporting to administrators.** Reporting to administrators required generating numbers. These numbers were used for staffing, and the reports compiled were for use by the district to report to the state and federal agencies. Her year-end report was an

example of reporting to administrators. To prepare her final report she would construct a 22-item report that summarized her school nursing activities, and the variety of ways she had responded to the children. To do that, I noticed her working at her computer, then looking to a notebook and a calendar that was located on her desk for information to complete her report. Compiling the report was a matter of checking the electronic records, generating numbers, and confirming meeting dates with a calendar she kept, as well as describing what she had been up to throughout the school year.

**Reporting to others outside the district.** Child Protective Services was an example of an outside agency that she might be asked to report to. On occasion, circumstances presented that Ann was required to document findings that would be sent to Child Protective Services (CPS). Her findings would be subsequent to what the teacher noticed. In cases of possible neglect or abuse the teacher would likely be the first to notice anything suspicious, and would send the child to her for an assessment. Ann documented the child's physical appearance at the time the child visited her office. Since the teacher discovered the possible abuse or neglect, the teacher would be the one who called CPS. Ann's documented anything related to health. Then when parents were called to meet with the school she provided information to parents and others what she documented in the health record. For Ann this was an opportunity to provide parents with information to help with physical or health care (e.g., determine if parent had misinformation) that might become an issue for follow-up by CPS. In other words, at a meeting with parents, teachers, and administrators she answered questions such as: What happened here? When instances of frequent absences from school were an issue for which CPS is notified, she would notice in the child's record if a doctor's note had been

supplied for long-term illness. She saw her role as one to encourage parents to request from the child's doctor a note documenting the illness. Her advice was helpful to avoid encounters with CPS. She acknowledged:

I can't tell a parent they have to, but I encourage them to take their child to the physician and to get a doctors note. The school is required to report frequent absences to the county attorney. This is done for excused and unexcused absences. It doesn't matter if the child is chronically ill such as with cancer. Communicating to parents in advance, when she knew the child was likely to have excessive absences, gives the county attorney information to waive any consequences. Informing parents of this added to their ability to provide care for their child.

### **Comments**

In this chapter, the account of Ann's effort to track information related to children's health was described as: 1) gathering and generating data; 2) recording data; and 3) reporting it. It is described as a quick and simple act (documenting electronically by clicking on a list of possible complaints and outcomes for one child in one encounter), and it is described as a meticulous time consuming compilation of health information about all the children.

Tracking health information of the children reflects their health status, and that can be used to advocate for their health. The compilation as a record served as the means to communicate with others and effectively advocate for preventive and primary health care. Throughout the year-long study, I noticed over and over, that in the Wiggle Creek health office, the medical care children received was often symbolic. It was through her extensive work to maintain health records that she was able to advocate for the medical

care that some children needed.

To summarize the act of tracking information, I return to my fieldnotes to present tracking children's dental health as a vignette. It brings together the phases of information tracking as a process that functioned to provide dental health at Wiggle Creek Elementary. It is told from her perspective.

When we get a document from the parent or a dentist that a child has had a dental visit we put it in the computer. Around the first of September I run a list of students that have seen a dentist since November of the previous year until that date. The ones that have no visit noted, we send out our letter to the parents. When these return, we document in the computer the ones that respond indicating their child has seen a dentist within the last year. Our visiting dentist screens all the rest. This is so much nicer than when we needed to do it by hand.

In November, the dental hygienist and a local dentist will be here. All children not having been checked within the year will be screened. I arrange the room so it will take a minimum of time (1 ½ hours) to keep a constant flow of kids moving through the screening. It takes some preparing to make it happen. I email the teachers the days and times that I want the children sent down. I prepare for gathering the dental check results by writing the children's names on a card and put these cards in the teachers' mailboxes. I also request that teachers tell their students to bring their cards with them when they come to the health office that day.

On screening day, children come to the health office in groups of five; when the first of the five gets done they are to ask their teacher for five more to be sent to the health office. This constant flow of children limits lines forming. It might not work smoothly, but I am flexible. I sit at a small table, retrieve their 3x5 card, and record on the card what the screener finds. A zero means no referral; a one indicates dental work is needed; and a two means three or more cavities are noticed.

Once everyone has been screened, I sort the cards recording the ones and twos first. For each child that scored a one or two their parents will be called to report the dentist's screening results. I also send their parents a short letter, and I follow up with one more phone call. That is three contacts to report dental screenings of the 'ones and twos'.

The first week in January, I begin selecting kids for the free dental visits that are provided for students at Wiggle Creek. If I'm not able to contact parents by phone or by letter I will make a home visit to get the consent or help complete the forms. I knock on doors to get parent signatures. There are complicated reasons why parents don't sign the consent form. Since the consent forms are written, sometimes they may not get signed because of limited English language use. I use my 'Jewish guilt' approach, that is, it is free, you don't have to do anything. There are 12 available spaces to fill from Wiggle Creek; I filled 11 last year. My effort focused on Kindergarten and 5<sup>th</sup> grades. The program is an elementary only one. Ten of the eleven were Medicaid. The dental clinic got reimbursed for the care given. A van from the State Health Clinic picks up the

participating children at school in the morning. The first visit may be just a cleaning. The second visit is when the cavities are filled or tooth pulling occurs.

This vignette of dental health care (i.e. the gathering, recording, and reporting health information) ends with my observing children returning from Ann's arranged dental visit. On one occasion, I noticed two of the children arriving in the health office. Ann acknowledged them and said, "Shut your mouth your teeth are so sparkly they hurt my eyes."

The school nurse worked in cooperation with the local dental health care providers to generate information about the dental health status of children that had not been to a dentist within the last year. She meticulously recorded the dental reports into the child's health records, and then began the process of reporting to parents the findings. She continued to indirectly care for the children advocating for those with three or more cavities to receive free dental care. When children reported back to her that they had been to the dentist she documented it in their health record and re-enforced the benefits of dental care – their sparkly smile. She would act in similar ways tracking other health information. As a state licensed nurse, her efforts were within the boundaries of school nursing practice. These efforts showcase not only her ability to act as an advocate for school children's health but also reflects the results of her continued effort to get children the care they needed to improve the possibility of staying in their classroom.

### **Endnotes**

<sup>1</sup> For information regarding Nebraska rules and regulations use the following link:

<http://nebraskalegislature.gov/laws/browse-chapters.php?chapter=79>

<sup>2</sup>Current guidelines and recommendations for school health screening practices in

Nebraska schools are found in the resource document, *Guidelines for School Health Services in Nebraska*, available from the DHHS School Health Program. Retrieved from: <http://www.dhhs.ne.gov/SchoolHealth/ScreeningBackground908.pdf>

<sup>3</sup>Information about the schools pre-school program can be found on the district's website using the following link: [http://wp.lps.org/Wiggle Creek/staff/ecse/](http://wp.lps.org/WiggleCreek/staff/ecse/) In general the federal program is one that provides for special education and related services to children to provide an opportunity to develop school readiness skills.



## **Chapter Eight**

### **Discussion**

This qualitative study describes what one school nurse does in an elementary school. To account for her nursing practice, the study relies on the conceptual framework of caring theory. In addition, to account for why she does what she does, the study relies on identity theory and social learning theory to understand and to give a description of her regularly enacted behavior. Behavior that was meant to improve student well-being, and subsequently improve attendance in the children's respective classrooms. My findings showcase her caring attitude, her professional duties (e.g., dispense medication, care for children with acute health care needs, and her efforts to manage health information) enacted as medical caregiver and teacher to reintroduce the obvious: provide health care to all children while they are in attendance at Wiggle Creek Elementary School.

### **Attribute of Caring**

Nursing in general and school nursing in particular both rely on the concept of 'caring for' individuals that have a health related need; it is primary to nursing practice. Thus, it is not surprising to see Ann acting in caring ways that are characteristic of what Watson describes as authentic caring that includes authentic listening and hearing, being present for another in the moment and being reflective. It is what I repeatedly found Ann doing throughout the year-long study of Wiggle Creek Elementary School's health office. Looking to caring theories (Watson, 1997; Noddings, 2005; Boykin & Schoenhofer's (2001) helps to conceptualize caring as it occurred in Ann's nursing practice. George (2002) asserts that Boykin & Schoenhofer's nursing as caring theory accounts for the

“caring perspective...as basic to a view of nursing as an undertaking that focuses on humans, provides service from person to person, exists because of a social need, and is a human science” (p. 542). Further, it was prominent in this study that “ the caring relationship can be considered an intervention in and of itself, or at least a core ingredient” (Watson, 2008, p. 73).

While I don’t accept all of Watson’s caring philosophy, I do agree with her ideas about caring relationships enhancing the possibility of healing outcomes. It seemed obvious as I presented the account of Ann administering medication, providing episodic health care, and tracking health information that a caring relationship was an intervention. Further, Potter & Perry’s (2005) perspective that “when clients sense a commitment on the part of the nurse and are willing to enter into a relationship” (p. 110) also helps to account for the relationship building that Ann regularly engaged in with the children. Her responsiveness as seen in the caring process enabled her to understand the children’s experience with the physical complaint that they presented to her.

As a caring person she was receptive, that is, she was attentive to individuals in a special way (Noddings, 2002). She often began the caring encounters with a question. An action that almost always elicited a response from the child. Ann’s questioning initiated dialogue between her, the ‘carer’ and the child, the ‘cared for.’ I repeatedly noted that the child, for example, smiled, walked with a quickened step or other actions that imply a positive recognition on their part as the ‘cared for.’ It iterates recognition on the part of the cared-for (child) that an act of caring had occurred (Noddings, 2002). The children shared with Ann in quiet conversations, responded without resistance to her requests. For example, her presence as close contact, and other actions such as eye

contact, body language, voice tone, listening, and having a positive and encouraging attitude created the health care encounters that were regularly enacted. To that end, the concept of caring helps to account for specific activities that Ann regularly engaged.

Further, what we know about Ann before she was a nurse supplements our understanding about her attitudes and actions. For example, knowing that she was a daycare provider before becoming a registered nurse helps to account for her motivation to care for children. What she had previously been socialized to now compelled her to act on behalf of the children.

In the year that I observed her interacting with children and adults, I also noticed that she conducted herself not only in direct caring ways, but also in ways that were closely associated with the act of caring conceptualized as indirect. Her indirect caring accounts for the extensive amount of time she spent tracking health information.

Throughout the study, Ann's stance was mediated by characteristics such as intuitive and communicator. Speculating that both her personal and professional stances are characterized by caring, it is not surprising to find her assuming roles that value advocating for children, or acting in ways that are reflective of caring in autonomous ways to provide for individual needs, such as assuming a case manager or teacher role on a case-by-case basis.

As I watched Ann participate in caring encounters, I wondered if what I had observed reflected what Nodding (2005) suggests ought to be taught in our schools. She suggests that "just as we now think it is important for girls as well as boys to have mathematical experience, so we should want both boys and girls to have experience in caring. It does not just happen; we have to plan for it" (p. 24). It is an interesting notion

that in Wiggle Creek's school health office boys and girls experienced caring in the health office. Furthermore, this study documents the social process of caring in a public school. Adults involved with children in a public school can learn from this particular school nurse the fundamental steps she repeated to build caring relationships with all children that she encountered. She found success in giving attention, empathizing and being responsive to children's needs as they saw them. As a result, she equipped the majority of children visiting the health office with an improved level of well being; a level that enabled them to return to their classroom.

### **Her actions: Professional Nursing Duties**

My fieldnotes are rich with descriptions of her responding to children in direct ways. The conditions varied, but her responses to them were consistent in following patterns of nursing practice and education practice. Patterns of practice were salient in the routine of daily medication administration and the procedure she followed to provide minor first aid for injuries and in other instances to assess child physical complaints associated with illness.

This report also showcases the outcome of child visits to the school nurse. Ann repeatedly sent children back to their classroom. Such phrases as "the child leaves with a smile and their hall pass in their hand to go back to class" or simply, "the child was sent back to class" were recurring in my fieldnotes. Less frequently occurring was that children were sent home. In such instances, her assessment of their physical condition had met district criteria for exclusion from school.

Equally significant were the repeated descriptions of her maintaining children's health records for every health related encounter that occurred in the health office.

Record keeping as an act of tracking health information consumed the majority of Ann's time. The health records she was responsible for were regularly used to interact with parents and others who directly worked with children in the Wiggle Creek School.

While presumably there are other possible arrangements for providing health care in schools, this study relied on the school nurse to describe from her perspective what she did. She encountered individuals with a variety of complaints and requests of her. Most complaints were physical, however some were social. On occasion she would get out her safety pins to fix a rip in clothing or use superglue to fix a broken shoe. Taken together, her activities to care for others is the account of what one school nurse does in a particular context to provide health care – mostly physical but other times it was mental and/or social health care.

To impact education outcome, Ann believed it was a matter of equipping children to manage their health in the classroom, and not to send them home. The assumption that this choice was in their best interest rested on how children interacted with her. She knew that when they had no fever, were given the opportunity to engage in a conversation with her, and the large doses of sympathy and care they received as a result of their caring encounter supported that their needs had been met, and were ready to return to their classrooms. If not, and a health problem persisted, they would return. When that occurred, she would assess their complaint, and begin again to assess the reason for why they had come to her.

### **Dispensing Medication**

As the school nurse, Ann played a direct role to improve the probability of children with chronic illness spending more time in their classroom seat (Anderson,

2009). It is estimated that 14% of U.S. children less than 18 years of age (Bloom, Cohen & Freeman, 2008) manage a chronic illness. Further, because it is suggested that we live in a society that associates giving medications as the primary treatment for the “restoration of health”, (Potter & Perry, 2005 p. 822) it is reasonable to assume that school nurses will regularly administer daily medications. Parents, teachers, district policy makers as well as the school nurse play a significant role in management of students’ chronic health conditions.

Further, indirect evidence to support that her efforts help children maintain therapeutic doses of their prescription medicine comes from statistics about attendance rates. Wiggle Creek Elementary has a 95% average daily attendance rate. (Nebraska Department of Education 2008-2009). It is implicit then that absences related to poor management of chronic health conditions would also be reflected in average attendance rates. Statistically, using 14% as the rate of managing chronic illness, Ann has the possibility of helping more than 50 children on a daily basis.

Ann was resourceful and strategic in dispensing medications to reduce time out of the classroom. Her efforts to provide management of chronic conditions as medical caregiver and as teacher were essential for improving educational outcome. She engaged children taking daily medications with conversation and supervision when they arrived to take their medicine. She also taught them to be responsible for their own health and take their medicine faithfully. For those taking capsules and tablets, she rewarded them on Friday with popcorn to celebrate. She believed that children participating in daily medication liked being a part of visiting the health office on a daily basis. By participating in the caring encounters daily, the students benefitted in being able to

function in their classroom. No doubt in the day-to-day routine, she had been responsible to help these students to gain new knowledge about their chronic condition, to change their attitude about self-management, and to adopt new behaviors to perform new skills that were essential for improving educational outcome (Potter & Perry, 2001).

Learning new health behaviors was meaningful for students managing asthma. I noticed children arriving regularly before they had asthma symptoms, and they were quickly on their way to such places as recess or physical education class. The health office had been a place for them to demonstrate that they had learned to manage their asthma.

### **Acute Health Episodes**

Wiggle Creek's administrators, teachers, and students knew that when they arrived in the health office they would receive attention from a caring medical expert for their physical complaint and also receive large doses of comfort and sympathy for why they had come. Ann's principal had described this attention as feeling comfortable, accepted and accommodated. She regularly listened to individuals describe why they had come; she would follow up with appropriate questions to make an assessment and determine how she would intervene to benefit the individual. She balanced a client driven accommodating model with one that was more 'business like'. In that sense it was to care for the problem and promptly return children to the classroom. The health office was not intended to be a lounge; the children knew that. Her principal described it this way: "The health office is open, a well defined environment where kids know they could have their needs taken care of, but it was also business and it was time to get going."

Further, teachers had first aid supplies in their rooms to manage the small, minor injuries. However, many of those were not cared for in the classroom but rather sent to the health office for the nurse to provide the care. A Band-Aid applied by a medical expert, such as Ann, would supply the attention, comfort, sympathy and expertise for what an injured child needed to re-focus on learning. In addition, because of her medical expertise she had the capacity to make an assessment that would parallel a diagnosis in a medical clinic. Her district did not allow her to make a diagnosis, but rather she made the recommendation that the child be referred to a medical care provider.

Any treatment Ann did was, mostly symbolic in nature. For example, she would apply a lotion to a localized rash, or have a child, complaining of a sore throat, gargle with a dilute salt solution. Her efforts were those that taught children to care for physical complaints without the use of medical interventions for successful resolutions and to get back to class. Ice packs, Band-Aids, a brief rest or attention from someone that they sensed cared about them was the ‘treatment’ that resolved the complaint. Other times it was in the best interest of the child to be sent home.

On most days, the children that Ann encountered came to her with a mix of physical complaints. Some of the complaints were of minor injuries; others were of conditions associated with possible infections such as stomachaches, headaches, tiredness, fevers, rashes and a range of upper respiratory symptoms such as coughing or sore throats. For most children it was simply summarized, as “I don’t feel good.”

The mix of complaints increased or decreased depending on the season – fall, spring or winter. For example, in the spring there were more rashes; in the fall and winter more upper respiratory complaints. But, no matter why a child had come her goal was



always to help them return to their classroom responsibilities. When their complaint met criteria for being sent home; she did that too. Often, as she cared for children, she found opportunities to teach them the skills in self-management of their health. For example, when she stood by their side as they washed a wound she might share knowledge about germs.

Beth, the trained health technician's efforts mirrored Ann's efforts to care for children in philosophy and in the procedures that were followed. Their assessment, doses of attention, and sympathy along with the 'healing qualities' of temperature checks, a short rest on one of the health office cots, and/or an ice pack when applied in either of their authoritative style were no doubt all that was necessary for the healing process.

Their assessment of health complaints did not vary. A pattern was noticeable for each child visit throughout the day. In general, the repeated behavior unfolded in sequential steps (Table 2). Each step was a deliberate step in the nursing process to provide care for individuals that arrived with a physical complaint. Asking the child their name initiated the assessment process and allowed for accessing the child's electronic health record. Consistent questions related to specific complaints (e.g., headache) provided information related to what the child knew. Then repeating specific procedures such as checking the child's temperature helped to uncover the child's current health status. As a result, children were either sent back to class, were kept for further observation, or sent home. Electronic documentation of the event always occurred, but it varied when Beth and Ann would enter the event in their computer.

Table 2 – Child Visit Patterns

School Nurse Process	Examples
Assessment:	Subjective:
Greet	•Hi, what can I do for you?
Ask questions	<ul style="list-style-type: none"> <li>• When did it start hurting?</li> <li>• Does your mommy know?</li> <li>• How did you sleep last night?</li> <li>• Did you eat breakfast?</li> <li>• Did you get hit or bumped on your head?</li> </ul>
Act on behalf of the child	Objective: <ul style="list-style-type: none"> <li>• Act on behalf of the child:</li> <li>• “Lets check your temperature.”</li> <li>• She listens to a child’s chest with her stethoscope.</li> </ul>
Identify action plan	<ul style="list-style-type: none"> <li>• “Do you want an ice pack?”</li> <li>• “Do you want to lie on the cot for 5 minutes?”</li> <li>• “I’ll call your mommy?”</li> </ul>
Implement intervention	<ul style="list-style-type: none"> <li>• Send child back to class</li> <li>• Allow child to lie on health office cot</li> <li>• Send child home</li> </ul>

Ann and Beth’s caring routine for physical complaints was carried out many times each day. It was the link to the thoroughness that Wiggle Creek’s Principal referred to and the attention that the children required. Her principal summarized the work of the school nurse this way: “If kids feel like they are being attended to, people care about them, and notice them, they are going to be more at ease, more settled and do better in school.”

### **Managing Health Information**

The task of maintaining health information for all students was a demanding job. Record keeping simply took most of her time. Her experience helped her to organize how she would gather, record and report it all in an orderly and efficient process. In the winter months she would spend more of her time with the follow-up for abnormal findings.

When she was gathering, recording, and reporting health screenings her time to engage in health care encounters with children was decreased. I sensed that Ann preferred to care for children directly, but understood the importance of record keeping and the impact it had in keeping children in their classroom. Her experience had taught her that the information that she was responsible for tracking would be useful to her, and also useful to other school personnel in making decisions about children's health and education.

Exploring the process of health record keeping as it occurs at school, enlightens about the kinds of information that a school nurse tracks and it showcases the importance of the school nurse as a provider of care at the preventive and primary levels of the healthcare delivery system. For example, at the preventive level she would provide education informally in situations that were ideal for face-to-face individual instruction and on other occasions that were formal in a classroom setting. Any regular health care she provided showcased her providing health care at the primary care level.

Preschool screening started in the first weeks of the fall semester. Later in September, she screened the older children for height, weight, hearing and vision. The process of screening for these vital statistics was combined and completed with one visit to the health office. However, when a deficiency was noted for hearing or vision, the child would need to be retested. With data recorded on worksheets, she later spent time entering the data into the electronic health records. Her work with maintaining health records gave the evidence she needed to communicate at a variety of meetings with educators and individuals outside the district.

Reporting health information, along with gathering and recording it, is another important thread interwoven into the fabric of record keeping. Because reporting health information plays a significant role in the account of what a school nurse does it was conceptualized as the third phase of information tracking. It is the means to communicate accurately about a child's health status. She regularly communicated documented information to children and their parents about their health status, and to educators as a collaborative effort to help the children maintain a high level of well being that enhanced learning. Further, she reported to agencies outside the Wiggle Creek School on a need to know basis.

Reporting health information benefits children through informing parents of identified deficiencies. Ann believed that communicating by phone was the most effective way; her conversation with parents about deficiencies would give her insight into how parents responded. She encouraged them to inform her of the results of any further medical care. For example, she kept track of children with vision deficiencies, and frequently asked the children if they got their new glasses.

It was interesting that early in collecting data, I noticed that Ann had described tracking information as her 'busy work.' Later, I understood that she had not meant for 'busy work' to be a negative concept, just caring that was more distant. For example, what she had labeled as 'busy work' on one occasion was the work she had done on a weight reduction plan for an individual child, yet it was her way of describing activities that are not face-to-face encounters. Other times, 'caring about' might involve making phone calls to benefactors and following up on leads that various staff had suggested that she utilize to help a family be able to afford trips to hospitals located a long distance from

their home, or to help a family be able to afford eyeglasses for their child when they could not qualify for government assistance.

### **Nurse as Medical Caregiver**

The nurse's role, within the context of an elementary school, is understood as medical caregiver and teacher. The two roles compliment each other, and when they are enacted in a public school context, they merge as one to accomplish providing health care to the individuals in the school building. At the beginning of the study, Ann described how she viewed what she did. She reminded me that "You are in an academic setting and everything is geared towards academics. Coming from a hospital that is **TOTALLY** (*her emphasis*) foreign. It took me a while to get my brain wrapped around that concept." Further she related to me that if there were vision problems, asthma, or diabetic problems she try to get them resolved. Her reference to an academic environment and her view of what health services must do is revealing about how Ann sees her work at Wiggle Creek Elementary as the school's nurse. Over 19 years of experience as a school nurse influenced her feelings and actions. She understood the culture of education. Her efforts logically would focus on medical care duties to enhance the possibility of performing academically.

A medical caregiver lens directs attention to viewing her actions as "assisting in identification, prevention and treatment of illness or injury"(Oxford University, 2011). However, Ann informed me on several occasions that her role was not that of someone who identifies illness or injury but rather someone who assists in the identification process. To iterate the district's position she shared with me that "nobody can do

anything about a child's pain except mom or dad." An assertion that articulated the role of parents in what she could do for their child while they were at school.

To sort through the complexity of medical caregiver in an education context, it is helpful to reflect on the level of care a school nurse provides within the spectrum of the U.S. health care delivery system (Appendix D). The spectrum expanse covers a range of providing for medical care with the intent that services are not duplicated (Potter & Perry, 2005). That said, as the school nurse, the health care levels Ann functions within are preventive and primary levels. At the preventive level, she functions to educate children about health management and knowledge. Simply put, she promotes health. As the school nurse at Wiggle Creek she provides preventive care in what she did to prevent disease. She spent an extensive amount of time with immunization compliance for all children. She also vigorously promoted participation of the second and third grade children in the dental sealant program.

The primary level of health care delivery directs attention to her efforts to identify early health deficiencies (e.g., screening) and routine care. Both activities required a significant portion of her time. She is the sites medical expert and her efforts facilitate well-being. Potter & Perry (2005) suggest that the preventive and primary levels of care showcase health promotion as a major theme. Ann was positioned to promote health with every encounter at this level. The study data supports her actions. Her assessment included some objective measures such as checking temperatures, having a close look with her special penlight, caring for a wound or listening to a chest with her stethoscope. Her behavior patterns are strikingly similar to those that unfold in ambulatory health clinics staffed by other health care providers. She was also skilled at and required to

respond to emergencies. In emergency critical care she was prepared to provide life support as a first aid responder, and would relinquish medical care to the emergency responders when they arrived.

Much of the medical care she delivered could also be described as symbolic. She was seen as the medical expert and her actions reflected those she had learned as a professionally trained nurse. The use of a medical lens to focus on what she did on daily basis is best described as medical triage. Applying nursing practice skills, she assessed the urgency of illness and injuries to decide what she would do for each one that entered her office for care. Her three choices were to send children back to class, allow them to rest on a cot for further observation, or to send them home. I noticed the encounters followed a pattern and were brief. Her actions focused on treating the child's response to their complaint. They received large doses of sympathy, comfort, or as Ann described it, "tender, loving care."

Her past work experience, with children in daycare and hospital settings, contributed to her specific responses. For example, I noticed her arms outstretched, as welcoming body language, that sent a clear, positive message to the children that she cared about them. Further, her professional nurses training and years of working as a school nurse equipped her to control or prevent the spread of disease and contributed to her being knowledgeable about indications or contraindications for medication therapy. As children arrived for doses of their daily medication (or if questions related to the medications effect) she had access to their health records. Access to this pertinent information gave her the opportunity to be aware of any history of allergies, length of time the medication had been taken, and other knowledge of their current conditions to

enhance the possibility of the safe administration of medication to children while they were at school.

It is not surprising that her realist worldview and her acceptance of what she could and could not control accounted for her seamless integration of the nursing process. Her philosophy to build relationships projects to others that she cares about them and has their interests in mind. Children responded utilizing the health office to receive the health care they had wanted, and Ann's actions functioned to improve the possibility that children would be healthy and in their classroom.

### **Nurse as Teacher**

A teacher lens directs attention to viewing her actions as a particular way of speaking engendering discourse that connects two worlds: teacher and learner. Implicit in this definition is that roles such as communicator, team player and relationship builder are valued too. Further, when a teacher is conceptualized as "someone that helps individuals gain new knowledge, change attitudes, adopt new behaviors or perform new skills" (Potter & Perry, 2005, p. 452) it follows that communication is central to teaching the new behaviors or new skills. Ann's efforts to teach regularly involved her communicating with children; some she engaged in conversation regularly (daily medications) and others it was random (e.g., "I don't feel good."), but she always engaged them in conversation. Communication was key to her efforts to care for health care needs of school-aged children. Did they want an ice pack or want to lie down on a cot for five minutes? Ann used her proven communication skills as an approach to help the child to gain skills and accept the responsibility to independently manage their health. In other words, communication was a frequently used tool to educate about health matters.



“Quality of communication is a critical factor in meeting the needs of individual’s, families, and communities” (p. 19, Potter & Perry, 2005). She communicated regularly with families, her colleagues, physicians, and school personnel (e.g., family care coordinator, social worker, special education teachers and other nurses employed in the district).

### **Informal Teaching**

For today’s professional nurse, teaching and learning is considered a major component of standard care (Potter & Perry, 2005). This study showcases that Ann regularly engaged in the act of teaching new behaviors and new skills within the enactment of caring for physical needs. Conceptualized in this way, it is viewed as informal and unplanned opportunities that occurred as Ann, for example, engaged in caring for a child struggling to manage an asthma attack. In this instance, while she administered or supervised the administration of the asthma medication she would sit with the child and explain that if they came in to the health office prior to exercise they could reduce or prevent breathing problems. Another frequently occurring example is of Ann caring for a child with a bloody nose; it too describes her informal teaching. A bloody nose is not life threatening, but can be frightening to an eight year-old as their blood begins to get on their clothing and skin. Informally teaching about simple first aid to pinch the nostrils tightly for three minutes teaches how to stop the bleeding and makes it less frightening. In these instances, children can ask questions and get her expert answers in casual conversations that she would engage them in while she remained close by. Her efforts demonstrate an important moment for the child about the proper actions and promote self-care, re-enforcing the behavior as she evaluated immediately the

progress that was made to manage the acute health problem. She concluded her conversation with be sure to tell mommy. She did expect the child to communicate with a parent about what had occurred. It too was learning to be responsible and learning to care for oneself.

The majority of her teaching opportunities were those that occurred in face-to-face encounters to explain health information. For example, it occurred on occasions when a child might be over the limit for Tylenol doses (district policy can have up to 5x Tylenol in 30 days) or when a child might want a cough drop (district policy is that child must bring a note for parent consent and supply the lozenges). At other times, it might be teaching children self-comforting strategies to reduce reliance on medicine to relieve pain. Their health education included resolving health issues without thinking of pills immediately.

### **Formal Teaching**

Other times teaching was planned and formal. For example, she taught formally the fourth and fifth grade students the district's growth and development curriculum, and she also taught the fourth graders the introductory lesson for Basic Aid Training. Her instruction reflected her knowledge of the children's cognitive abilities and capacity to learn. Showing her 'crazy side' was one of her favorite teaching tools. She reasoned that "it was helpful to get their attention, it made them more alert, they listened better, and it was rare for any one of the children to not get, or know what I said." Her assessment of student learning showed that it had worked. Other basic aid instructors, such as fireman, often reported to her that the students knew what to do in emergency situations. They

assured her that she had prepared the children well, and that they were ready to expand their knowledge of basic aid.

Prescreening education relied on her opportunity to address entire grade levels prior to children participating in health screening. For the youngest ones she would teach them about the ‘game’ they would play when they came to her room and explain what they would see and hear. The older children would learn about how to act responsibly. For the dental health screen it would require parent consent for sealants. In this more formal teaching, she would talk to them about the importance of returning the parent’s consent form.

### **Ethical Responsibility to Teach**

“Nurses have an ethnical responsibility to teach their clients” (Potter & Perry, 2005, p. 452). That said, Ann regularly acted in ways that acknowledged her understanding of her responsibility to anticipate what the children needed to know about their physical conditions or treatment plans. In her role as teacher, she regularly functioned to explain health information, and she often clarified health related information for children and adults alike.

### **Significance of the Study**

This study promotes an understanding of a school nurse’s perspective, and showcases what the nurse does for all children that arrive in her office for care. It strengthens and adds to previous research associated with health care and education in public schools at the individual nurse level of care. It is not surprising that the study found the school nurse actively engaged with children caring for them in direct or indirect ways to meet their felt needs or needs that had been planned by others (e.g., their parents,

educators, and in collaboration with outside medical care providers) when they arrived in the health office.

Ann is a key player in the academic outcome of students as it relates to being in their classroom. Ann and I frequently visited about how she saw her herself positioned to help in the process of educating youth; the study provided the evidence for what she did. She served as an advocate for all students in her particular building. Sometimes she advocated for wearing glasses, or was persistent in contacting parents to consent for free dental care for the three large cavities that needed to be taken care of, or she simply walked a tearful seven year old back to the cafeteria to eat with her friends rather than eat in the health office, again.

This study also promotes the concept of care. Ann serves as a role model to care for others. She regularly established caring relations with students, parents and staff when they entered the health office. For some she had the opportunity to maintain the caring relationship. For example, it was natural for her to maintain relationships with children that regularly came for their daily medication. The relationship building that occurred in the health office adds to previous research associated with caring in schools (Noddings, 2005). Exploring the concept of caring and the relationship building that regularly occurred, between Ann and the children she encountered, provides insight related to issues of educating all children. Repeatedly, children arrived for medical care, but they left with assurance they were healthy (or steps to take to improve their physical, social and mental health). This assurance was reflected in their body language as they left the health office to go back to class. Often, I noted in my fieldnotes that a child had smiled or laughed with Ann, and then sent back to class.

The idea of an interpretive study implies a researcher vantage point and the subjectivity that such a process is likely to entail. Another researcher might interpret the findings in different ways. Addressing issues with the interpretive process early on in this report positions me as the researcher, and my personal bias for the reader. However, personal bias might also be seen as a strength. Interestingly, Corbin & Strauss (2008) suggest that personal experience may be a valuable resource in getting the participant's story right. My personal experience as a health care professional and health education instructor provides for special insight to notice relationship building, creation of dialogue and responsiveness by those being cared for.

### **Ethical Considerations**

On occasion, encounters with the nurse were categorized as confidential and were stricken from the written record to protect privacy. As the principal investigator, I had an agreement with the school nurse that no confidential information would be recorded either through observation or as text in interviews. The nurse determined that confidential information was not collected as data for this study. To give individuals a voice, as they interacted with Ann throughout the study, pseudonyms were assigned and other details of what occurred were fictionalized to provide anonymity. The goal of the research study was to gather data that reflected the nurse's perspective; not that of the individuals she encountered.

### **Conclusion**

This qualitative study provides insight about health care in one public school and the nuanced ways it occurred. The nurse's caring attitude characterized her practice as she delivered care at the preventive and primary levels of health care in the U.S. Health

Care Delivery System. Her nursing duties consisted of daily medication administration, episodic care, and tracking health information. Tracking health information included monitoring the students' immunization compliance and acute outbreaks of contagious diseases. It also included screening for physical abnormalities such as poor vision, hearing loss, obesity, and poor dentition. Attention to the school nurse's activities brings to the fore the possibility that ALL children enrolled in a U.S. public school have free and ready access to health care while they attend school. This school nurse anticipated that she might be the only health care provider for some children. Keeping ALL children healthy is an enormous task.

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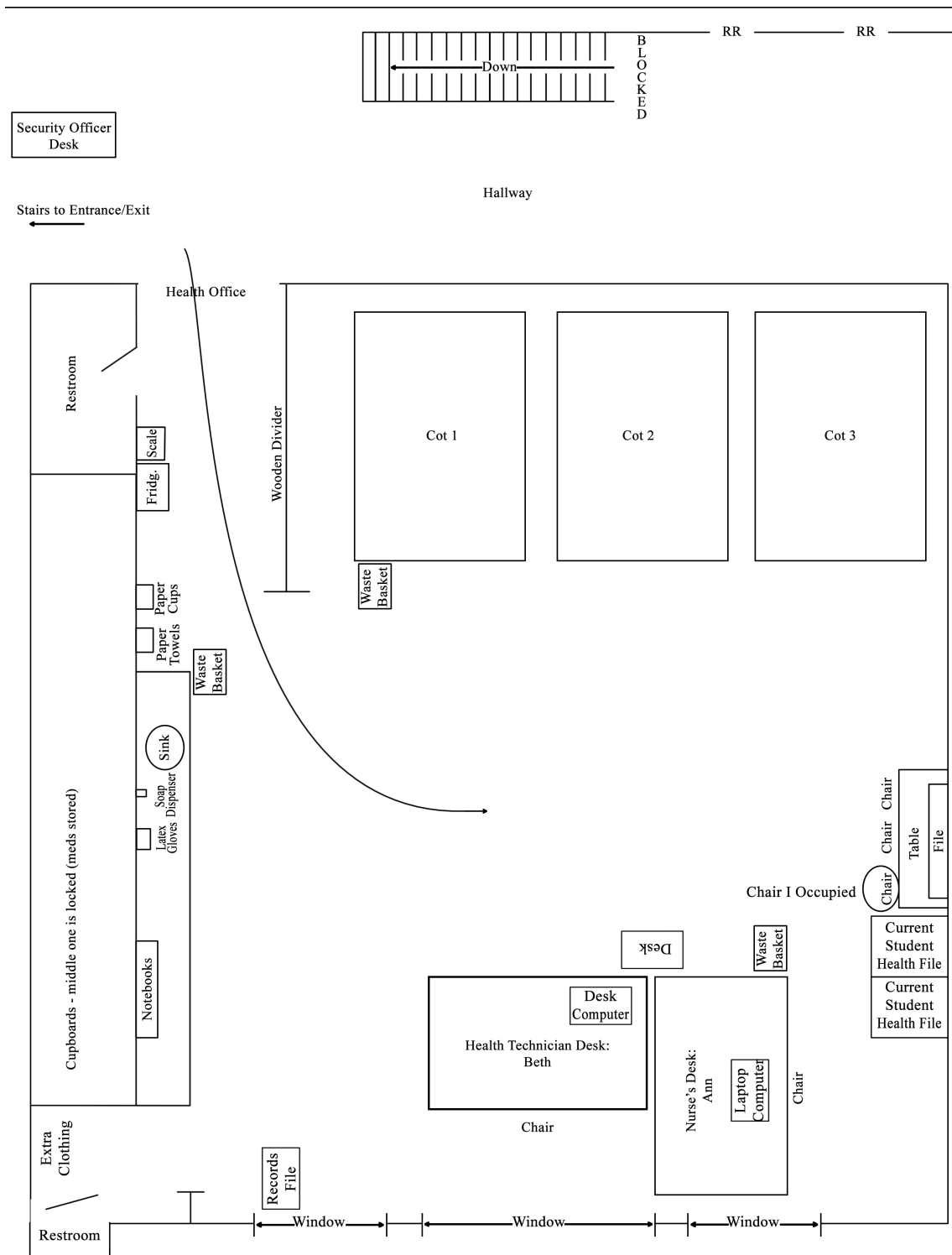
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## Appendix A

### Health Office Sketch



## **Appendix B**

### **Prescribed Duties of a School Nurse**

Two lists of required duties of the school nurses were found: 1) the National Association of School Nurses, a national organization that supports school nursing and “promotes student success through the advancement of school health services by professional registered school nurses” and 2) the participant’s district website. The two lists are copied to further inform about prescribed school nursing activities.

#### **National Association of School Nurses:**

- Provide direct health care for students and staff to facilitate ability to function successfully in the classroom (e.g., dispensing prescription medications for chronic illness);
- Provide leadership for the provision of health services (i.e., managing, within the scope of her professional nursing license, existing problems and or disabilities and working with other professional health care providers in doing that);
- Provide/advocate for student participation in existing services (i.e., serve as a liaison between school personnel, family, community, and health care providers);
- Conduct screening for health conditions (e.g., vision, hearing, height, weight, and dental screenings and other health screening seen as necessary for this particular population);
- Monitor immunizations (i.e., assure appropriate exclusion from and re-entry into school);



- Report communicable diseases as required by law;
- Promote health (e.g., provide education to students, staff and families through presentations at conferences, school meetings or individual instruction about such things as asthma management); and
- Serve as a leader in the implementation of health policies and programs. (NASN Brief, 2010 Retrieved from: <http://www.nasn.org/AboutNASN>)

### **Participant's District Website**

The Health Services Program contributes to the educational success of each student by promoting a safe and healthy environment for learning. This is accomplished by:

- Health screening
- First Aid and medication administration
- Immunization monitoring
- Communicable disease control
- Responding to medical emergencies
- Health education
- Management of chronic health conditions

(Retrieved from <http://www.lps.org/stuserv/health/>)

## Appendix C

### Overview of Research: Theoretical Framework

Research Paradigm: Constructivist postpositivist	Researcher Perspective: Constructivist realist	Research Strategies: Constructivist postpositivist Inquiry	Research Methodology: Ethnographic Approach
<u>Generalization</u> : not primary concern; studied case is of intrinsic interest; reader generalizes <u>Nature of Data</u> : verbal text of how individual makes sense of their everyday life; rely on participant thick, rich description <u>Data Analysis</u> : analysis of text obtained through observation and interviews; inductive approach <u>Credibility/Trustworthiness</u> : a) prolonged engagement b) thick description c) member checking d) triangulation (sources, theories, tools of ethnographic methods e) researcher reflexivity	<u>Ontology</u> : (Hatch, p. 14 & 15) reality exist, but is never fully apprehended thus construction of reality by individuals, as they see it, occurs regularly <u>Epistemology</u> : (Hatch, p. 14 & 15) what can be known is an interpretation of reality and partially constructed by how individuals make sense of what they do.	Study design references: • Hammersley, & Atkinson, (2007) • Hatch (2002) • Creswell (2007) • Corbin & Strauss (2008) • Agar (1996). • Spradley (1979)	<u>Data sources</u> : 1. Observation 2. Interviews 3. Reflexive journal of researcher  <u>Data gathering</u> : 4. Fieldnotes 5. Audio recorded interviews  <u>Data Analysis</u> 6. Transcription of interviews, fieldnotes, and reflexive journal 7. Constant comparative method of coding and theme analysis (Spradley, 1979; Corbin & Strauss, 2008)

## Appendix D

### U.S. Health Care Delivery System

Levels of Care	Description	Examples School Nurse Care
Preventive Care	Education	Health promotion: <ul style="list-style-type: none"> <li>• Growth and development;</li> <li>• Basic aid training; and the</li> <li>• Explaining to individuals to promote health</li> </ul>
	Prevention	<ul style="list-style-type: none"> <li>• Immunization compliance</li> <li>• Dental sealants</li> </ul>
Primary Care	Early Detection & routine care	<ul style="list-style-type: none"> <li>• Health Screens</li> <li>• Episodic assessments</li> <li>• Emergency First Aid</li> <li>• Management of chronic illness <ul style="list-style-type: none"> <li>- daily meds,</li> <li>- asthma care</li> <li>- diabetes</li> </ul> </li> </ul>
Secondary Care (Acute Care)	Emergency Treatment Critical care (intense and elaborate diagnosis and treatment)	
Tertiary Care	Special Care (highly technical services for clients in a large geographical area)	
Restorative Care	Intermediate Follow-up care (surgical postoperative routine care, routine medical care)	
	Rehabilitation	
	Home care	
Continuing care	Long-term care Chronic care Personal care Hospice care	Care of medically fragile